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FORWARD

LETTER OF CONCURRENCE

February 1, 2011

Angie Tuttle
Grants Management Officer
Centers for Disease Control and Prevention
Procurement and Grants Office
Branch 1-Team 2, M/S E-15
2920 Brandywine Road
Atlanta, GA 30341-4146

Dear Ms. Tuttle:

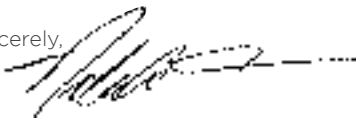
This letter reflects the Community Planning Group of Southern Nevada's (CPG-SoN) and Northern Nevada HIV/AIDS Planning Council's (NNPC) concurrence with the 2011 – 2016 Nevada State Comprehensive HIV Prevention Plan submitted by the Nevada State Health Division (NSHD). The CPG-SoN and NNPC Co-Chairs offer this letter of concurrence, reflective of the votes submitted by CPG-SoN and NNPC members.

The process included:

- Meeting of CPG-SoN and NNPC to develop priority populations and key elements of the plan on March 15, 2010;
- Presentation of 2011 – 2016 Nevada State Comprehensive HIV Prevention Plan core elements to CPG-SoN and NNPC by August 15th, 2010;
- Opportunities to provide feedback and questions to NSHD staff;
- Cast votes of concurrence, concurrence with reservations, or non-concurrence by November 15, 2010.

We appreciate the inclusion of CPG-SoN and NNPC in the review of the 2011 – 2016 Nevada State Comprehensive HIV Prevention Plan and the community planning process.

Sincerely,



Natalie Clarkson
CPG-SoN Public Health Co-Chair



Gerold Dermid
NNPC Public Health Co-Chair

SECTION ONE

INTRODUCTION

NORTHERN NEVADA HIV/AIDS PLANNING COUNCIL AND COMMUNITY PLANNING GROUP OF SOUTHERN NEVADA

Prior to 1994, local communities were only indirectly involved in decisions regarding funding and priorities for HIV prevention in Nevada. The Centers for Disease Control and Prevention (CDC) first mandated community planning for HIV prevention in 1993. Nevada's HIV Prevention Community Planning Group (CPG) was formed in 1994 and began as a statewide planning body.

The CDC's commitment to strengthen community-based HIV prevention interventions was the motivating factor in beginning the community planning group process. The CDC considers community planning an, "essential component of a comprehensive HIV prevention program" and this is a requirement for federal funding. This process involves people infected and affected by this disease. The CDC's HIV Prevention Community Planning Guidance is our road map for this process, defining the roles and responsibili-

ties, as well as the components in the community planning process.

According to the CDC's HIV Prevention Community Planning Guidance there are three goals in community planning:

- † The community planning process supports a broad-based community participation in HIV prevention planning.
- † Community planning identifies priority HIV prevention needs in each jurisdiction.
- † Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

The Northern Nevada HIV/AIDS Planning Council and Community Planning Group of Southern Nevada are the official HIV planning bodies for the state of Nevada, as mandated by the CDC.

This is a collaborative effort between the Nevada Department of Health and Human Services/Health Division, Washoe County Health District, Southern Nevada Health District, Carson City Health and Human Services, HIV-infected and affected communities, state and local HIV prevention providers, and other concerned parties, to improve HIV prevention service delivery in Nevada. The planning group members come from all walks of life, such as HIV/AIDS activists, staff of the Nevada State Health Division; local health department representatives, service providers, staff and volunteers from community-based organizations, and concerned and committed citizens.

Originally, a statewide CPG was formed in 1994, following the mandate by the CDC with the goal of strengthening and improving the existing HIV prevention efforts, as well as building infrastructure in the state. The community planning process builds on these efforts and incorporates the views of affected persons and community members. This participatory process informs, shapes, and assists in the development of this Comprehensive HIV Prevention Plan.

The Nevada State Health Division takes the information from the Comprehensive State HIV Prevention Plan and incorporates it in the state's annual funding application to the CDC. This funding, in turn, is used for HIV prevention programs and interventions statewide.

Members of the CPGs participate via monthly meetings and standing committee meetings. This process is facilitated using co-chairs, who keep the community planning process flowing smoothly and who ensure the community planning process stays on schedule. Once community planning decisions are made, these proposals are placed before the CPG for final vote, allowing for healthy debate on the issues.

“**HIV** does not make people dangerous to know, so you can shake their hands and give them a hug: Heaven knows they need it.”

-Princess Diana

What is a Comprehensive HIV Prevention Plan?

The primary responsibility of a CPG is to develop a comprehensive HIV prevention plan that includes prioritized target populations, community services assessment, gap analysis, and effective activities/interventions targeting the priority populations. The priority populations are determined based on epidemiological data and on the ability to provide the greatest impact on the number of new HIV infections. This plan assists local health authorities and state policy makers on making health care decisions to best meet the needs of its citizens.

ACKNOWLEDGEMENTS

The development of this plan was a coordinated effort requiring the input of many talented individuals. We would like to gratefully acknowledge the contributions of all the current community planning group members and the staff of Washoe County Health District, Southern Nevada Health District, and Nevada State Health Division, who actively contributed to the 2011 – 2016 Nevada Comprehensive State HIV Prevention Plan. The dedication to HIV prevention community planning and contributions to the HIV prevention field will be felt for many years, well beyond 2011 – 2016 time line proposed by this plan. Countless other individuals contributed to the development of this 2011 – 2016 Comprehensive State HIV Prevention Plan. We wish to acknowledge the support of former community planning group members and appreciate their contributions to the prevention of HIV in Nevada. The past work has been a guiding force in the writing of this plan.

SECTION TWO

COMMON ACRONYMS AND KEY TERMINOLOGY

COMMON ACRONYMS USED IN COMMUNITY PLANNING

AI/AN	American Indian/Alaska Native
AIDS	Acquired Immune Deficiency Syndrome
API	Asian and Pacific Islander
ART	Antiretroviral Therapy
ASO	AIDS Service Organization
CBO	Community Based Organization
CCHHS	Carson City Health and Human Services
CDC	Centers for Disease Control and Prevention
CLI	Community Level Intervention
CPG	Community Planning Group
CPG SoN	Community Planning Group of Southern Nevada
CRCS	Comprehensive Risk Counseling Services

CTR	Counseling, Testing, and Referral
CTS	Counseling and Testing Services
DEBI	Diffusion of Effective Behavioral Interventions
DIS	Disease Investigation Specialist (North)
DIIS	Disease Investigation and Intervention Specialist (South)
EBI	Effective Behavioral Intervention
eHARS	Electronic HIV/AIDS Reporting System
ELISA	Enzyme-Linked Immunosorbent Assay (HIV screening test)
Epi	Epidemiology
FaR	Frontier and Rural Areas of Nevada
FBO	Faith Based Organization
GLI	Group Level Intervention
HAART	Highly Active Antiretroviral Therapy
HC/PI	Health Communication/Public Information
HE/RR	Health Education/Risk Reduction
HIV	Human Immunodeficiency Virus
HRSA	Health Resources Services Administration
IDU	Injection Drug Use
ILI	Individual Level Intervention
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex

MSM	Men Who Have Sex With Men
NR/NIR	No Reported/No Identified Risk
NNPC	Northern Nevada Planning Council
NSHD	Nevada State Health Division
PCRS	Partner Counseling and Referral Services
PEMS	Program Evaluation and Monitoring System
PEP	Post Exposure Prophylaxis
PI	Public Information
PIR	Parity, Inclusion, and Representation
PLWA	Persons Living with AIDS
PLWH	Persons Living with HIV
PrEP	Pre-Exposure Prophylaxis
RFA	Requests for Applications
RFP	Request for Proposals
SNHD	Southern Nevada Health District
STD/I	Sexually Transmitted Disease/Infection
TA	Technical Assistance
WCHD	Washoe County Health District
YMSM	Young Men Who Have Sex with Men (< 25 years of age)

KEY TERMINOLOGY

AIDS

Persons diagnosed with HIV and t-cell count of < 200 and/or an opportunistic infection.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The federal agency dedicated to protecting the health and safety people. The CDC funds a variety of HIV and STD prevention programs and initiatives.

COMMUNITY PLANNING GROUP

The CPG is a statewide planning group that provides community perspectives, advice and recommendations concerning HIV prevention to the Nevada State Health Division. The CPG is divided into two regions, the Northern Nevada Planning Council and Community Planning Group of Southern Nevada.

DIAGNOSIS DATE

The date in which an HIV or AIDS case was diagnosed with a confirmatory test.

EPI PROFILE

Description of HIV morbidity and mortality among individuals and geographic areas over time.

EPIDEMIOLOGY

The study of the distribution and determinants of health and disease in the population.

HIV INFECTION (HIV/AIDS)

Persons diagnosed as HIV positive within a given year, regardless of AIDS status.

HIV NOT YET AIDS	The diagnosis of HIV infection prior to the progression of HIV into AIDS.
INCIDENCE OF HIV/AIDS	The total number of newly diagnosed cases of HIV and/or AIDS within a specific period of time.
INCIDENCE RATE	The number of newly diagnosed cases occurring with a specific time period divided by the population at risk, often expressed per 100,000 population.
MODE OF TRANSMISSION	The way in which an infection was passed from one person to another. In describing HIV/AIDS cases, this identifies how an individual may have contracted HIV, such as injection drug use or sexual contact.
MORTALITY	The number of deaths per 100,000 people.
PEDIATRIC CASES	AIDS diagnoses among infants and children (< 12 years of age) at age of diagnosis.
PEMS	The Program Evaluation and Monitoring System that collects data related to HIV prevention and education activities.
PREVALENCE OF HIV/AIDS	The number known cases living with HIV/AIDS (new and old) within a specified period of time.
PREVALENCE RATE	The number known cases living with HIV/AIDS (new and old) within a specified period of time divided by the population at risk, often expressed per 100,000 population.

RATE CALCULATION

Calculating rates is generally a better indication of the burden of disease for a given population as it allows for comparison between other states, age groups, and race/ethnicities. A rate allows populations with dissimilar sizes to be compared. A rate is calculated by dividing the number of individuals with a disease in a given time period by the population size at risk for the disease multiplied by 100,000.

REPORT DATE

The date in which a confirmed HIV or AIDS case is reported to the HIV Surveillance Program.

**RYAN WHITE TREATMENT
EXTENSION ACT OF 2009 (RWTEA)**

Formerly the Ryan White CARE Act and the Ryan White Treatment Modernization Act. The RWTEA was signed into law October 30, 2009 and extended previously authorized federal funding to improve the quality and availability of care for individuals infected/affected by HIV/AIDS four years through September 30, 2013.

SURVEILLANCE

An ongoing, systematic collection, analysis, evaluation and dissemination of data regarding specific health conditions and diseases, in order to monitor these health problems.

SECTION THREE

CORE EPIDEMIOLOGICAL QUESTIONS

What is the scope of HIV/AIDS in Nevada?

The HIV/AIDS epidemic has affected persons in all sex, age and racial/ethnic groups and all counties in Nevada. This effect, however, has not been the same for all groups. In the beginning of the epidemic, the number of cases of HIV infection increased most noticeably among White MSM. Although White MSM are still disproportionately affected by the epidemic, recent trends suggest a shift in the HIV/AIDS epidemic toward, Blacks, youth, and heterosexual adults.

To plan for HIV prevention and care and to allocate limited resources as the epidemic continues to change and the number of persons living with HIV continues to grow, it is extremely important to identify those populations most affected and most at risk for HIV infection.

This section provides detailed information about location of the HIV epidemic throughout Nevada, demographic and risk characteristics of HIV-infected persons and trends in the statewide epidemic. It describes cases diagnosed in 2008 and five-year trends from 2004 through 2008. Unless noted, all data come from Nevada's HIV/AIDS Surveillance Program.

HIGHLIGHTS

- In 2007, Nevada ranked 26th in the nation of the number of new AIDS cases and 29th in the nation among HIV Infection Cases Reported among States with Confidential Name-Based Reporting, 2007 (1=High, 51=Low).

- There are persons living with HIV in every county in Nevada, and the number continues to increase each year. At the end of 2008, a total of 7,940 persons were known to be living with HIV/AIDS in Nevada, 4,123 (52%) of whom had a diagnosis of AIDS.

- In 2008, there were 435 new HIV infections diagnosed in Nevada. Among these new diagnosis 91% (394) were diagnosed in Clark County, 8% (34) in Washoe County, and 2% (7) in the FaR areas in Nevada.

- The HIV diagnosis rate for Blacks continues to be disproportionately high and, in 2008, was more than 6 times higher than that for Whites. Although, in 2008, only 27% of newly diagnosed HIV infections were in the Black population, they had the highest rate at 61 per 100,000 population.

- Among all races/ethnicities, male-male sexual activity remains the predominant mode of ex-

posure and has seen increasing trends over the past five years. Among Blacks, heterosexual contact has increased significantly since 2004.

- Men continue to lead the epidemic in Nevada among all racial and ethnic groups in Nevada. In 2008, women represented 15% of new HIV infections and have been declining since 2004. The proportion of Black women have remained relatively stable; yet among both Hispanics and Whites increased slightly from 2004 to 2008.

- Because of the introduction of new legislation which improved screening programs for pregnant women and the increased use of antiretroviral therapy in pregnant women and their infants, perinatal transmission rates have dropped dramatically (there were no perinatal HIV cases in 2008) .

- Since 1996, the number of new AIDS cases and deaths of persons with AIDS has decreased dramatically, coinciding with the widespread use of antiretroviral therapy. However, data from recent years indicate a leveling or a reversal of these declines, which may be due to factors such as late testing; limited access to, or use of, health services; and the limitations of current therapies.

How Does Nevada rank?

According to Henry J. Keiser Family Foundation Health Statistics (2007), Nevada ranked 26th in the nation for the number of new AIDS cases; the annual AIDS case rate for males was higher than the national AIDS case rate (25.6 vs. 22.9); ranking males 10th in the nation for AIDS cases in Nevada. Additionally, Nevada ranked 29th in the nation among HIV Infection Cases Reported among States with Confidential Name-Based Reporting, 2007 (1=High, 51=Low).

Note: Rates have been adjusted for reporting delays. Data source: HIV/AIDS Surveillance Report, 2007. Vol. 19, Table 11. Maps not to scale

FIGURE 1
History of HIV/AIDS and mortality in Nevada 2004-2008

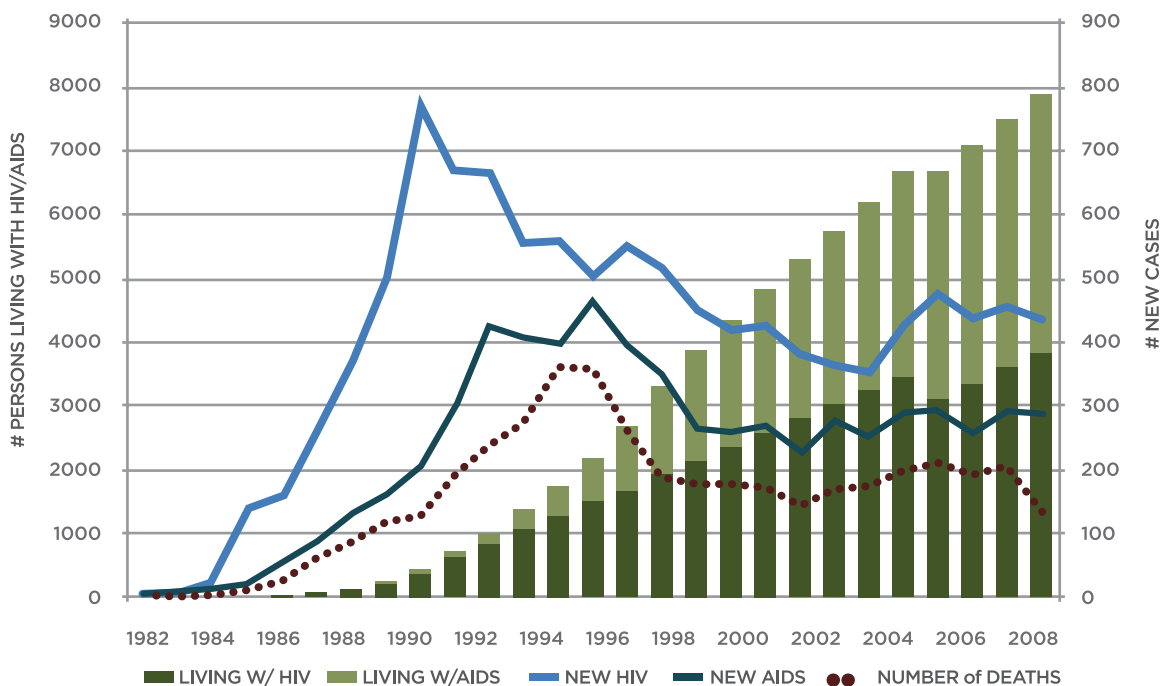


TABLE 1
Summary of HIV/AIDS in Nevada by demographics and risk factors: 2008

COUNTY	NEW HIV INFECTIONS			LIVING WITH HIV/AIDS		
	N	%	rate*	N	%	rate**
Clark	394	91%	20.0	6,643	84%	337.6
Washoe	34	8%	8.0	805	10%	189.9
All other counties	7	2%	2.1	470	6%	139.3
Unknown county (NV)	0	0%	-	22	0%	-
TOTAL	435	100%	15.9	7,940	100%	289.9

SEX						
Male	368	85%	26.5	6,617	83%	475.8
Female	67	15%	5.0	1,323	17%	98.1
TOTAL	435	100%	15.9	7,940	100%	15.9

RACE/ETHNICITY						
White, non-hispanic	191	44%	11.2	4,308	54%	253.4
Black, non-hispanic	116	27%	61.3	1,861	23%	983.7
Hispanic	107	25%	16.7	1,488	19%	232.9
Asian/Pacific Islander	12	3%	6.9	180	2%	103.5
American Indian/Alaska Native	4	1%	11.0	70	1%	192.2
Multi-race	5	1%	N/A	33	0%	N/A
TOTAL	435	100%	15.9	7,940	100%	15.9

AGE AT DIAGNOSIS						
<13	0	0%	0.0	60	54%	0.0
13-24	64	15%	13.6	823	23%	175.0
25-34	120	28%	29.9	2,865	19%	714.8
35-44	130	30%	32.0	2,780	2%	684.7
45-54	78	18%	20.9	1,090	1%	292.1
55-64	35	8%	12.3	274	0%	96.4
65+	8	2%	2.6	48	100%	15.7
TOTAL	435	100%	15.9	7,980	100%	15.9

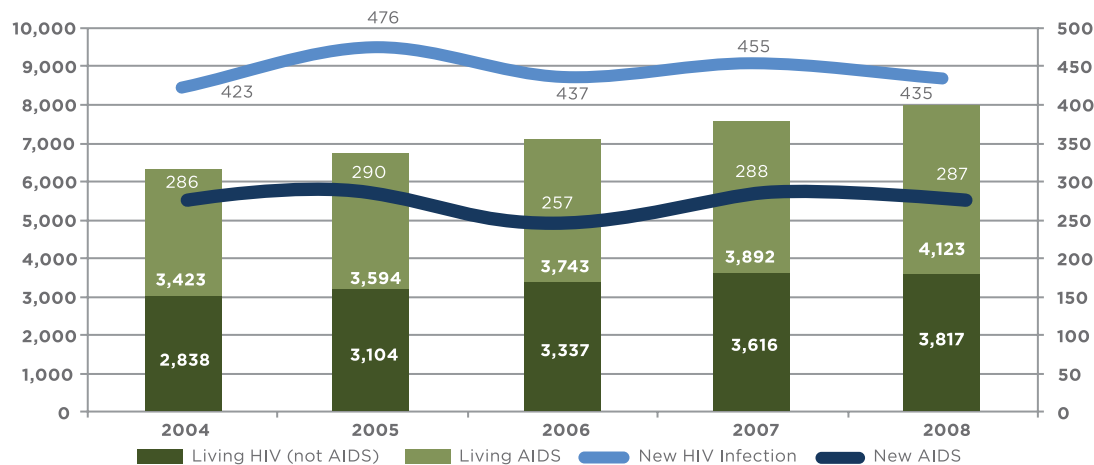
RISK OF TRANSMISSION						
MSM	293	67%	N/A	4,751	60%	N/A
MSM & IDU	19	4%	N/A	530	7%	N/A
Heterosexual contact	80	18%	N/A	1,001	13%	N/A
IDU	33	8%	N/A	819	10%	N/A
Perinatal exposure	0	0%	N/A	55	1%	N/A
Adult Hemophilic/Blood Transfusion	0	0%	N/A	15	0%	N/A
NRR/NIR	10	2%	N/A	769	10%	N/A
TOTAL	435	100%	N/A	7,980	100%	N/A

*Cumulative incidence rate per 100,000

**Prevalence rate per 100,000

FIGURE 2

Annual number of persons living with HIV/AIDS, and new HIV and AIDS cases in Nevada: 2004-2008



The prevalence of HIV (not AIDS) and AIDS in Nevada can be combined and are represented as the total number of persons living with HIV/AIDS in Nevada. Numbers of persons living with HIV/AIDS is obtained from the Nevada HIV/AIDS Surveillance reporting system (eHARS) and is based on current address in the given year; cases may have not necessarily been diagnosed with HIV/AIDS in Nevada.

For the purpose of this report, all data will be reported on using the HIV/AIDS combined numbers, as this is the best representation of the prevalence.

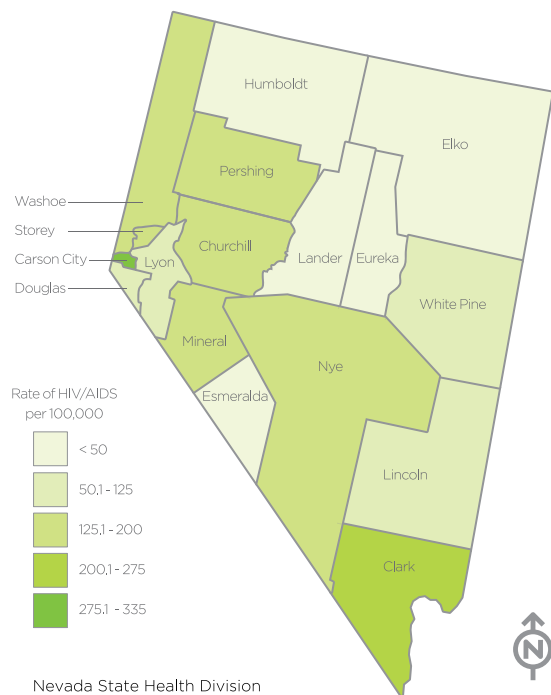
From 2004 through 2008, the number of HIV (not AIDS) and AIDS cases living in Nevada has increased steadily overtime.

In 2004, the number of persons living with HIV (not AIDS) was 2,838 compared to 3,817 in 2008; representing a 34% increase. The number of persons living with AIDS was 3,423 in 2004 compared to 4,123 in 2008; representing a 20% increase.

Overall, an estimated 7,940 persons were living with HIV/AIDS in Nevada, in 2008 representing a 27% increase since 2004. The

FIGURE 3

Rate per 100,000 of persons living with HIV/AIDS, in Nevada by county: 2008



increase in persons with HIV/AIDS living in Nevada may be attributable to the increase in total population growth of Nevada during this same time period as well as individuals living longer with HIV/AIDS.

The incidence of newly diagnosed HIV infections and AIDS cases in Nevada is obtained from the Nevada HIV/AIDS Surveillance re-

porting system (eHARS) and is based on the date of confirmatory lab results. The numbers of new HIV infections and AIDS cases represent the number of individuals who were diagnosed in the given year; this number often overlaps with new HIV infections due to the co-occurring diagnoses of HIV and AIDS and therefore cannot be combined.

For the purpose of this report all data will be reported on using the outcome of new HIV infection, as this is the best representation of incidence.

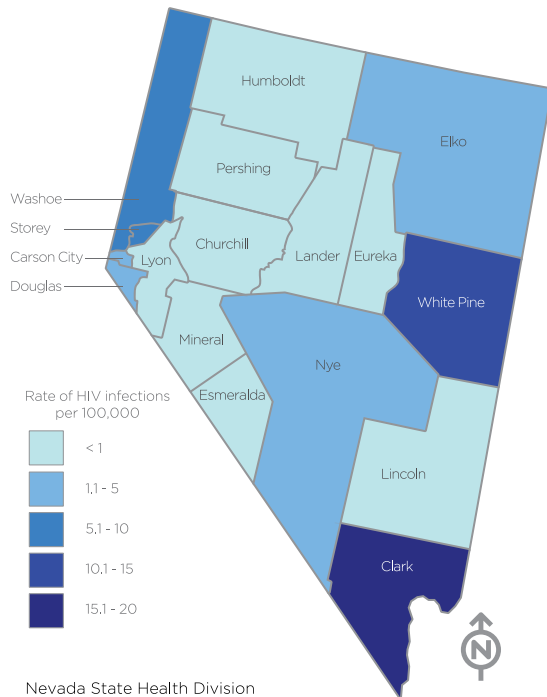
From 2004 through 2008, the number of newly diagnosed HIV infections has increased slightly from 423 new HIV infections in 2004 to 435 in 2008; representing a 3% increase; while there was no increase in the number of new AIDS diagnoses during this same time period.

The greatest annual decrease for new HIV infections and AIDS diagnoses occurred from 2005 to 2006 followed by a steady increase from 2006 through 2008. The increase in the number of new HIV infections and not an increase in new AIDS cases may be an indicator that individuals are testing early or living longer with HIV before converting to AIDS.

When we look at the rate of persons living with HIV/AIDS (prevalence rate) we get a different picture from the spatial mapping of

FIGURE 4

Rate per 100,000 of new HIV infection in Nevada by county: 2008



newly diagnosed HIV Infections. Clark and Washoe counties continue to contribute the greatest morbidity; however, rates among other counties are also alarming.

The spatial distribution of the rates of persons living with HIV/AIDS in 2008 in Nevada shows that the highest rate of prevalence of HIV/AIDS are located in Clark County (rate of

334.1 per 100,000). Pershing, Churchill, Mineral and Nye counties stand out, but the real surprises are Storey County and Carson City.

The rate of persons living with HIV/AIDS in Carson City is in the same category as Clark County and Storey County which has the second highest rates of persons living with HIV/AIDS. In 2008, the rate of persons living with HIV/AIDS in Carson City was 310.08 per 100,000; followed by Storey County with a rate of 228.2 per 100,000.

Although Washoe County has the second largest population in Nevada, this area has the fourth highest rate of persons living with HIV/AIDS in Nevada (189.9 per 100,000).

New HIV infections in Nevada reflect the population distribution in Nevada. Looking at the spatial distribution of new HIV infections in Nevada it becomes immediately obvious that Clark County accounts for the greatest number of new HIV infections in the state. In 2008, the rate of new HIV infections in Clark County was 20 per 100,000 population.

White Pine County has the second highest rates of new HIV infections in Nevada in 2008, the high rate may be driven more by its low population (less than 10,000 residents) rather than a true high morbidity area, as there

were less than five new HIV infections in this county in 2008. Washoe County, the second most populous county in Nevada, had the third highest rate (8.0 per 100,000) of new HIV cases in 2008.

For Carson City, Douglas, Elko, and Nye Counties the rates of new HIV infections were between 1.1 and 5.0 per 100,000. Although these counties are small in population and the number of new cases, the impact of new cases in this area is significant as access to resources and care are difficult in these areas of Nevada.

FIGURE 5
Number of new HIV/AIDS infections in Nevada by sex 2004-2008

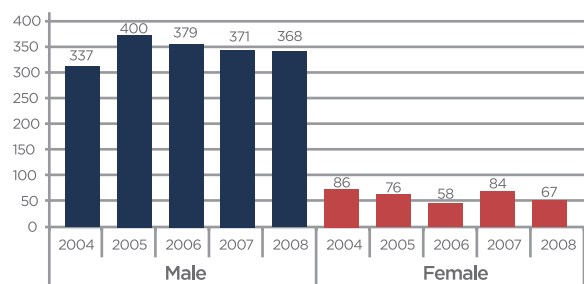


Figure 5: From 2004 to 2008, the number of new HIV infections increased among males. In 2008, the number of new HIV infections among males was 368; representing a 9% increase since 2004. The most significant increase was from 2004 to 2005, followed by a

steady decline. From 2004 to 2008, the number of new HIV infections decreased among females. In 2008, the number of new HIV infections among females was 67; representing a 22% decrease since 2004.

FIGURE 6
Annual number of new HIV/AIDS infections in Nevada by race/ethnicity 2004-2008

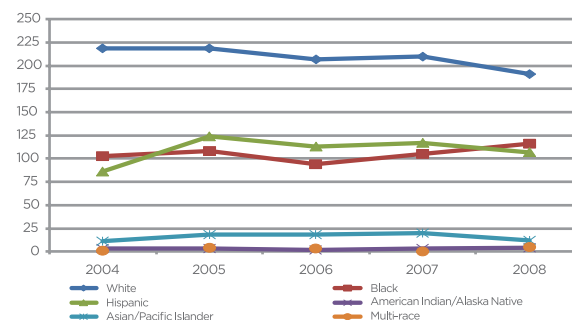


Figure 6: From 2004 to 2008, the number of new HIV infections declined among Whites yet increased among Blacks and Hispanics. In 2008, the number of new infections among Whites was 191; representing a 15% decrease since 2004. In 2008, new infections among Blacks was 116 and 107 among Hispanics; representing a 13% and 25% increases since 2004, respectively.

Among all other races there were no significant changes from 2004 to 2008. Asian/Pacific Is-

landers accounted for 12 of the new cases in 2008, American Indian/Alaskan Natives accounted for four, and multi-race persons accounted for five of the new cases in 2008.

FIGURE 7

Annual number of new infections in Nevada by age at diagnosis 2004-2008

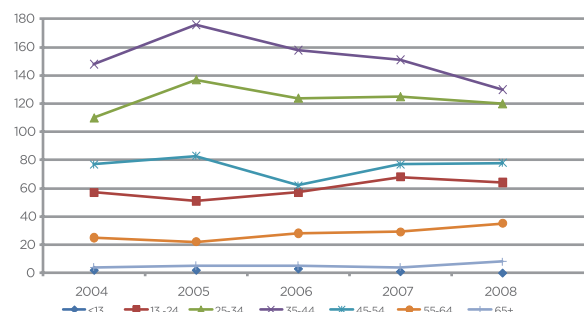


Figure 7: In 2008, there were no new HIV infections among individuals less than 13 years old. From 2004 to 2008, the number of new HIV infections increased most significantly among 13-24 and 25-34. In 2008, the number of new infections among individuals 13-24 was 64 and among 25 to 34 years olds was 120; representing a 15% and 9% increase since 2004, respectively.

From 2004 to 2008, there was a steady decline among individuals 35 to 44 years of

age. In 2008, the number of new HIV infections among 35 to 44 years old was 35; representing a 12% decline since 2004. There was a 4% increase of new HIV infections among 55-64 and a 50% increase among those 65 years and older.

FIGURE 8

Annual number of new HIV infections in Nevada by risk of transmission 2004-2008

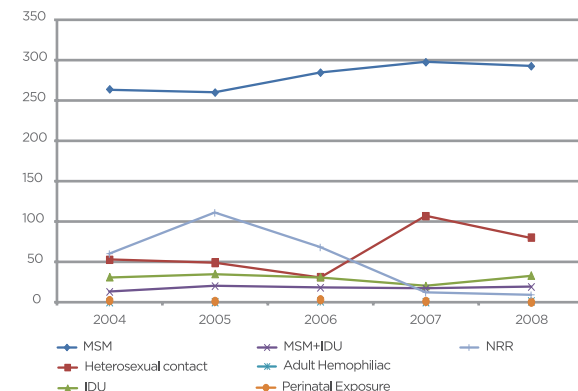


Figure 8: MSM accounted for more than two-thirds (67%) of the new HIV infections in Nevada in 2008. MSM increased 11% annually from 2004 to 2008. Although heterosexual contact only accounted for 18% of the new HIV infections in 2008, it increased from 53 cases in 2004 to 80 in 2008; representing a 51% increase.

Trends of IDU (6% increase) and a combined risk of MSM and IDU (46% increase) have shown to be an increasing risk of HIV transmission in Nevada from 2004 to 2008. In 2004 there were two perinatal HIV cases and decreased to zero. NRR/NIR cases in Nevada decreased 85% from 2004 to 2008.

FIGURE 9
Annual number of persons living with HIV/AIDS in Nevada by sex 2004-2008

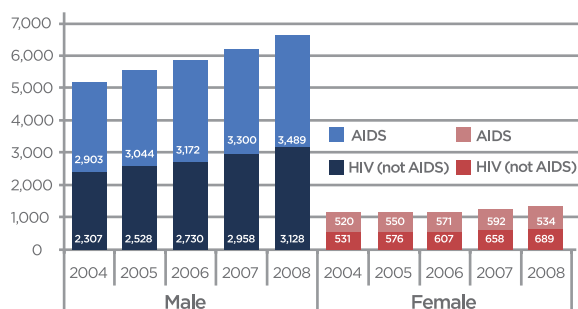


Figure 9: From 2004 to 2008, the number of males living with HIV/AIDS in Nevada increased 27% from 5,210 cases in 2004 to 6,617 in 2008. Among females living with HIV/AIDS in Nevada, in 2004 there were 1,051 females living with HIV/AIDS in Nevada and in 2008 there were 1,323; representing a 26% increase.

Although a greater proportion of the male cases are AIDS compared to females; for both males

and females, there was a greater increase among HIV (not AIDS) compared to AIDS cases from 2004 to 2008. This could suggest improved case management.

FIGURE 10
Annual number of persons living with HIV/AIDS in Nevada by race/ethnicity 2004-2008

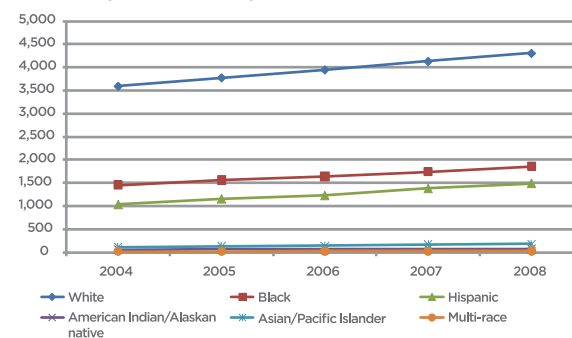


Figure 10: From 2004 to 2008, among persons living with HIV in Nevada there was an increase among all race and ethnicities. The most significant increase (with the exception of multi-race with an 83% annual increase) was among API, which increased 59% from 113 cases living with HIV/AIDS in 2004 to 180 in 2008.

This increase was followed by Hispanics which increased 44% during this same time period, Blacks, which increased 28%, American Indians/Alaskan Natives, which increased 21%, and Whites which increased 20% among the persons living with HIV/AIDS in Nevada from 2004 to 2008.

FIGURE 11
Annual number of persons living with HIV/AIDS Nevada by age at diagnosis 2004-2008

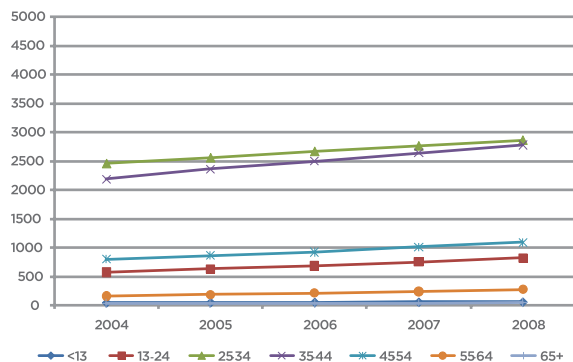


Figure 11: Among persons living with HIV/AIDS in Nevada there was an upward trend in all age groups. The most significant annual increases were among 55-64 year olds which increased from 161 cases in 2004 to 274 cases in 2008; representing a 70% increase.

This was followed by 13-24 year olds which increased 44%, 45-54 year olds which increased 36%, 35-44 year olds which increased 27%, less than 13 year olds increased 25%, and 25-34 year olds increased 16% from 2004 to 2008 among persons living with HIV/AIDS in Nevada.

These trends show that individuals are living longer with HIV/AIDS as we are seeing a significant increase among older individuals. MSM and IDU have increased 7% and 12%

respectively during this time period. Perinatal exposure has increased 22% from 2004-2008, though there were no positive perinatal HIV cases in 2008.

FIGURE 12
Annual number of persons living with HIV/AIDS Nevada by risk of transmission 2004-2008

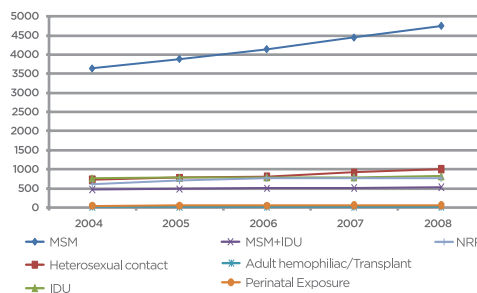


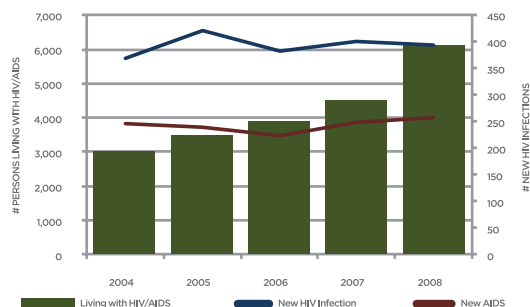
Figure 12: MSM continually represent the greatest number of cases as primary risk factor among persons living with HIV/AIDS in Nevada and increased 30% annually from 2004 to 2008.

This is followed by heterosexual contact which has increased 38% from 2004 to 2008 and between 2007 and 2008 has become the second most commonly reported primary risk factor. IDU and a combined risk of MSM and IDU have increased 7% and 12% respectively during this time period.

CLARK COUNTY

FIGURE 13

Number of persons living with HIV/AIDS and new HIV infections in Clark County, Nevada 2004-2008



Clark County is located in Southern Nevada. The county had a population of 1,967,716 according to the 2008 interim population estimates, accounting for 72% of Nevada's population.

Clark County contains the city of Las Vegas, the state's most populous city. The population density was 174 people per square mile in 2006. The county's population was spread out with 25.60% under the age of 18, 9.20% from 18 to 24, 32.20% from 25 to 44, 22.30% from 45 to 64, and 10.70% who were 65 years of age or older. In 2006, the median age of people in Clark County was 34 years.

About 7.9% of families and 10.8% of the population were below the poverty line, including 14.1% of those under age 18 years.

LIVING WITH HIV/AIDS

The number of persons living with HIV/AIDS has increased significantly from 2004 to 2008. As of December 2008, there were an estimated 6,643 persons living with HIV/AIDS compared to 5,235 in 2004, representing a 20% increase in number of persons living with HIV/AIDS in Clark County from 2004 to 2008. The prevalence rate of persons living with HIV/AIDS in Nevada was 337.6 per 100,000 population.

NEW HIV INFECTION AND AIDS

From 2004 through 2008, the number of newly diagnosed HIV infections and AIDS cases in Clark County has remained relatively

TABLE 2

Number of HIV infections in Clark county, Nevada by facility at diagnosis 2008

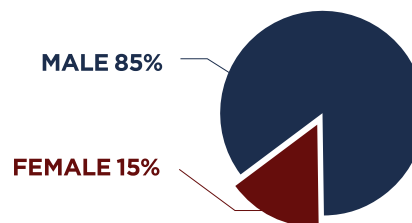
TYPE OF FACILITY	NUMBER HIV INFECTION DIAGNOSED	% TOTAL DIAGNOSED CASES
SNHD	150	38%
Hospital	109	28%
PMD	91	23%
VA	14	4%
INDOC	10	3%
Other	10	3%
METRO/VICE	6	2%
OOS	4	1%
TOTAL	394	100%

consistent. Between 2005 and 2006, there was a slight decrease in the number of new HIV infections and from 2006 to 2008 there was an increase in the number of new AIDS cases. In 2004, Clark County had 368 new HIV infections and in 2008 there were 394;

representing a 9% increase. The number of new AIDS cases increased only 1% from 2004 to 2008 with 247 cases in 2004 and 258 cases in 2008. The rate of newly diagnosed HIV infections in Clark County in 2008 was 20 per 100,000 population.

Among the new HIV infections in Clark County, more than one-third (38%) were diagnosed by the Southern Nevada Health District (SNHD), 28% from a hospital in Clark County, 23% from a private medical provider (PMD), The

FIGURE 14
Percent of new HIV infections in Clark County, Nevada by sex 2004-2008



rearming were diagnosed at the Veterans Administration (VA) (4%), Nevada Department of Corrections (NDOC) (3%), Other health care facility (3%), Metro/Vice (2%), and out of state facility (1%). In 2008, in Clark County 85% (n=294) of the new HIV infections were among males and 15% (n=59) were among females. The rate of new HIV infections among males in Clark County in 2008 was 33.4 cases per 100,000 population compared to the rate of new HIV infections among females was 6.1 cases per 100,000 population.

FIGURE 15
Trends of new HIV infections in Clark County, Nevada by sex 2004-2008

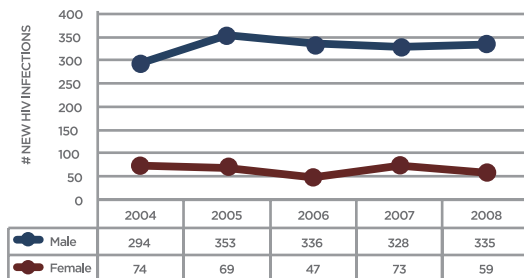
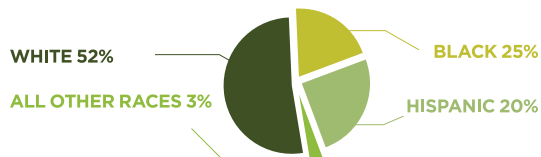


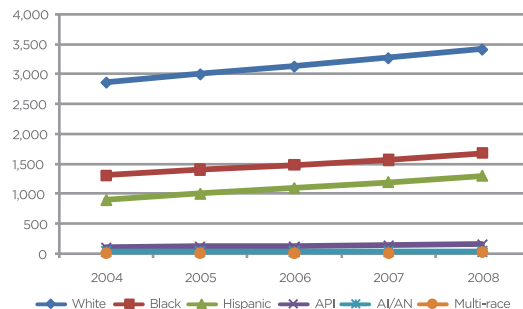
FIGURE 16
People living with HIV/AIDS in Clark County Nevada by race/ethnicity 2004-2008



The proportion of new HIV Infections among females over the past five years (2004-2008) has decreased, while increasing among males in Clark County. The prevalence of males living with HIV/AIDS in Clark County increased 28% annually from 2004 to 2008 while females living with HIV/AIDS in Clark County increased 23%. The number of new HIV infections increased 14% among males while decreased 20% among females from 2004 to 2008.

In 2008, among persons living with HIV/AIDS in Clark County, the greatest proportion of cases was White (52%). Blacks, accounted

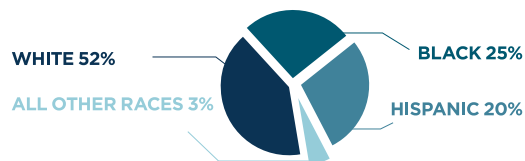
FIGURE 17
Trends of people living with HIV/AIDS in Clark County, Nevada by race/ethnicity: 2004-2008



for 25% of persons living with HIV/AIDS while, Hispanics accounted for 20%, and all the other races combined accounted for 5% (2% API, 1% AI/AN, and 0% Multi-race) of the persons living with HIV/AIDS.

From 2004 to 2008, the number of Whites living with HIV/AIDS increased 19%, while the number of Blacks increased 28%, Hispanics 45%, API 56%, and AI/AN 18% in Clark County.

FIGURE 18
Percent of people living with HIV/AIDS in Clark County, Nevada by race/ethnicity 2004-2008



Among newly diagnosed HIV infections, less than half (41%) were White, more than a quarter (26%) were Hispanic/Latino persons, Black, accounted for slightly less than a third (28%), and all the other races combined accounted for five percent (3% API, 1% AI/AN, and 1% multi-race) of the new HIV infections in Clark County.

FIGURE 19
Trend of new HIV infections in Clark County, Nevada by race/ethnicity 2004-2008

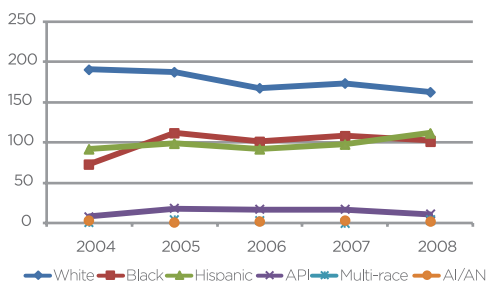
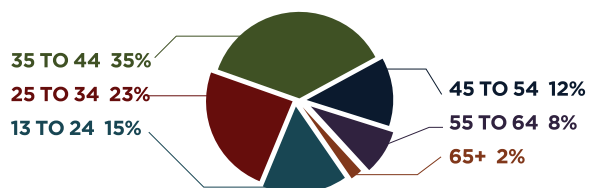
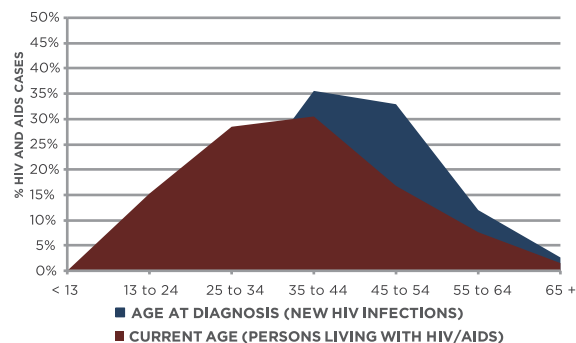


FIGURE 20
Percent of new HIV infections in Clark County, Nevada by age at diagnosis 2008



In this same time period, there was a 40% increase in the number of newly diagnosed HIV infections among Hispanics, a 22% increase among Blacks, and a 38% increase among API. However, there was a decrease in the number of Whites (15%) and AI/AN (33%). The proportion of new HIV infections in 2008 in

FIGURE 21
Percent of HIV and AIDS cases in Clark County, by age at diagnosis compared to current age - 2008

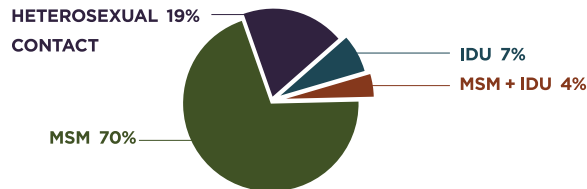


Clark County, was greatest among 35-44 year olds (30%, n=120) and 25-34 year olds (28%, n=112). Youth (13-24) accounted for 15% (n=60), and there were no new HIV cases among individuals less than 13 years of age.

Twenty-seven percent of new HIV infections were among those 45 years or age or older. Those 45-54 accounted for 17% (n=66) of the new HIV infections, 55-64 year olds 8% (n=60), and 65 and older accounted for 2% (n=6).

FIGURE 22

Percent of HIV diagnosis in Clark County, Nevada by risk factor of transmission - 2008



From 2004 to 2008, among newly diagnosed HIV infections, 55-65 year olds experienced the greatest annual percentage growth of 36% followed by 13-24 year olds and 25-34 year-olds in Clark County, Nevada in 2008.

Among new HIV infections in Clark County, there were more cases diagnosed between 25-34 years of age while, at the end of 2008 (age as of December 31, 2008) among persons living with HIV/AIDS in Clark County are primarily among the 35-54 age groups. Therefore, HIV/AIDS cases are showing to be diagnosed at a younger age; the cases currently living with HIV/AIDS in Clark County, Nevada are among older age groups.

Male to male sexual contact (MSM) was the most prevalent primary risk factor for persons with new HIV diagnoses in Clark County in 2008. In 2004, 64% of new HIV infections were among MSM compared to 70% in 2008, representing a 16% growth in cases with MSM

as primary risk factor for HIV infection. Heterosexual contact was the second most commonly reported primary risk factor for HIV infection in 2008 and experienced the most significant increase over the past five years.

In 2004, 13% of new HIV infections had heterosexual contact as the primary risk factor compared to 19% in 2008. This increase represents a 63% annual percentage growth from 2004 to 2008. This may be a result of more thorough case follow-up as opposed to an increase in this behavior.

Injection drug use (IDU) is the third most common risk factor among new HIV cases, accounting for 7% of new case risk factors in 2008. In 2004, 25 of newly reported cases had IDU as primary risk factor compared to 27 in 2008 in Clark County; representing a slight increase (8%) in cases with a risk of IDU. Persons with newly diagnosed HIV who had the combined risk of MSM and IDU increased 46% from 10 cases in 2004 to 14 cases in 2008. Persons with this combined risk accounted for only 3% in 2004 and 4% in 2008 of the total new HIV diagnoses.

In 2008, although there were children born to HIV positive mothers (perinatally exposed to HIV) in Clark County, there were no new perinatal HIV positive cases reported in Clark County.

TABLE 3

New HIV and AIDS diagnosis and persons living with HIV/AIDS in Clark County, Nevada by Demographics and risk factors: 2008

SEX	AIDS		HIV INFECTIONS		LIVING WITH HIV/AIDS	
	N	%	N	%	N	%
Male	217	84%	335	85%	2,929	85%
Female	41	16%	59	15%	518	15%
TOTAL	258	100%	394	100%	3,447	100%

RACE/ETHNICITY						
White	103	40%	163	41%	1,748	51%
Black	69	27%	112	28%	858	25%
Hispanic	73	28%	102	26%	719	21%
API	10	4%	11	3%	84	2%
AI/AN	2	1%	2	1%	27	1%
Multi-race	1	0%	4	1%	11	0%
TOTAL	258	100%	394	100%	3,447	100%

AGE AT DIAGNOSIS						
< 13	0	0%	0	0%	19	1%
13 to 24	16	6%	60	15%	187	5%
25 to 34	58	22%	112	28%	1,192	35%
35 to 44	98	38%	120	30%	1,309	38%
45 to 54	55	21%	66	17%	576	17%
55 to 64	25	10%	30	8%	147	4%
65 +	6	2%	6	2%	17	0%
TOTAL	258	100%	394	100%	3,447	100%

RISK FACTOR						
MSM	182	71%	275	70%	2,229	65%
Heterosexual contact	46	18%	75	19%	428	12%
IDU	23	9%	27	7%	374	11%
NRR/Other	3	1%	3	1%	159	5%
MSM + IDU	3	1%	14	4%	229	7%
Perinatal exposure	1	0%	0	0%	21	1%
Adult Hemophilic/Blood	0	0%	0	0%		
Transfusion					7	0%
TOTAL	258	100%	394	100%	3,447	100%

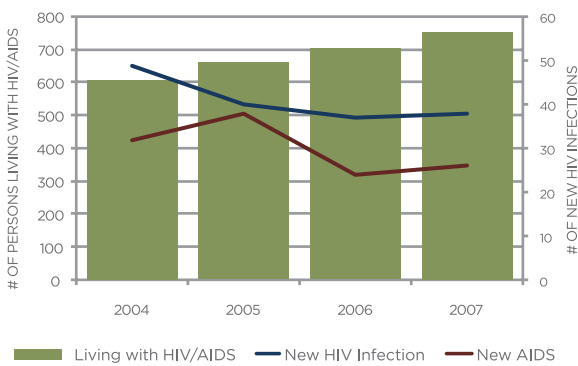


WASHOE COUNTY

Washoe County is comprised of the cities Reno and Sparks. As of 2000 Census, the land area of Washoe County was 6,342.27 square miles and the population density was 53.5 people per square mile (21/km₂). According to the United State Census Bureau, the estimated population in Washoe County in 2008 was 410,000. From April 1, 2000 to July 1, 2008 Washoe County experienced a 21% increase in population.

Males accounted for 50.8% of the total population in Washoe County and females 49.2%. The racial makeup of the county was 67.7% White, non-Hispanic, 2.6% Black or African American, 2.1% American Indian/Native American, 5.0% Asian, and 0.5% were Native

FIGURE 23
 Number of persons living with HIV/AIDS and new HIV infections in Washoe County, NV: 2004 - 2008



Hawaiian or other Pacific Islander. Persons of Hispanic or Latino origin accounted for 21.2% of the population.

In the county the population was spread out with 16% were under the age of 13, 34% were between 13 and 24 years of age, 14% were 25-34, 15% were 35 to 44, 15% were 45 to 54, 11% were 55 to 64, and 11% were 65 years of age or older. The median income in 2007 in Washoe County was \$54,524 and 10.2% of persons living in Washoe County were below the poverty line.

LIVING WITH HIV AND AIDS₂

Among the 805 persons living with HIV/AIDS in Washoe County 45% (n=362) were only HIV (not AIDS) while 55% (n=443) were documented AIDS cases. The number of persons living with HIV/AIDS has increased from 604 persons living with HIV/AIDS in Washoe County in 2004 to 805 in 2008, representing a 33% increase. The prevalence rate of persons living with HIV/AIDS in Washoe County in 2008 was 193 per 100,000 population.

1.NOT AIDS 2.HIV/AIDS

NEW HIV INFECTIONS AND AIDS

From 2004 through 2008, the number of newly diagnosed HIV infections and AIDS cases in Washoe County had decreased. In 2004 there were 49 new HIV infections in Washoe County accounting for 12% of the total new infections in Nevada. In 2008,

there were 34 new HIV infections accounting for 8% of total new cases in Nevada.

From 2004 to 2008 there was, a 31% decline in new HIV infections in Washoe County. The cumulative incidence rate of new HIV infection in Washoe County in 2008 was eight per 100,000 population.

The number of new AIDS in Washoe County cases decreased as well by 25% from 32 new AIDS cases in 2004 to 24 new AIDS cases in 2008. The cumulative incidence rate of new AIDS cases in Washoe County in 2008 was six per 100,000.

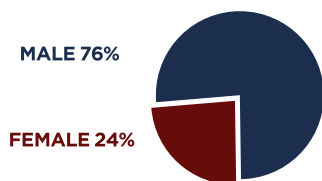
TABLE 4

Number new HIV/AIDS infections in Washoe County, Nevada by facility - 2008

TYPE OF FACILITY	NUMBER HIV INFECTION DIAGNOSED	% TOTAL DIAGNOSED CASES
Other	8	24%
PMD	7	21%
HOPES	7	21%
WCHD	6	18%
Hospital	5	15%
OOS	1	3%
TOTAL	34	100%

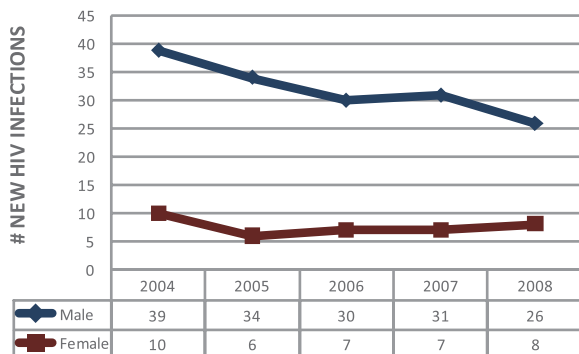
Among the new HIV infections diagnosed in Washoe County in 2008, 24% were in other medical facilities, 21% by a Private medical provider (PMD), 21% by Northern Nevada HOPES, 18% from the Washoe County Health District, 15% from a hospital in Washoe

FIGURE 24
Percent of new HIV infections in Washoe County, Nevada by sex.



In 2008, in Washoe County, 76% of the new HIV infections were male and 24% female. The rate of new HIV infections among males in Washoe County in 2008 was 12.1 cases per 100,000 population while the rate of new HIV infections among females was 3.8 cases per 100,000 population.

FIGURE 25
Trends of new HIV infections in Washoe County, Nevada by sex.



The proportion of new HIV Infections among females over the past five years (2004-2008) has decreased among both males and females in Washoe County. The number of new HIV infections decreased 33% among males and 20% among females from 2004 to 2008. However, the prevalence of males living with HIV/AIDS in Washoe County increased 30% from 2004 to 2008 while among females living with HIV/AIDS in Washoe County increased 54%.

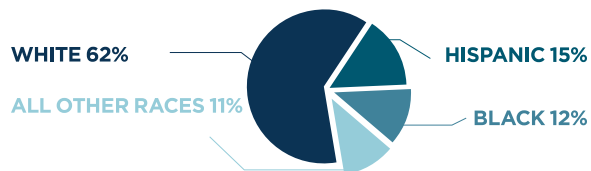
FIGURE 26
Percent of persons living with HIV/AIDS in Washoe County, Nevada by race/ethnicity: 2008



In 2008, among persons living with HIV/AIDS in Washoe County, the greatest proportion of cases were among Whites, accounting for more than two-thirds of the cases (67%), followed by Hispanics 17%, 13% were Black, and all the other races combined accounted for 5% (2% API, 2%, AI/AN, and 1% multi-race) of the cases living with HIV/AIDS.

Percent of new HIV infections in Washoe County, Nevada by race/ethnicity: 2008

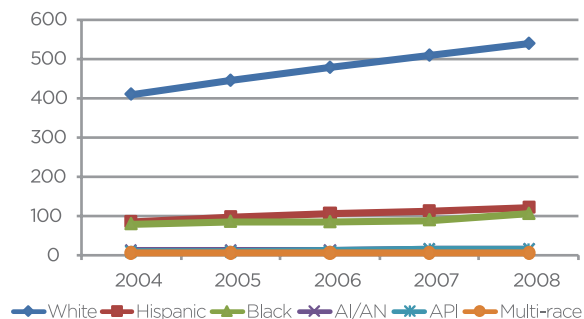
FIGURE 27



Among newly diagnosed HIV infections, almost two-thirds (62%) were White, 15% were Hispanic, 12% were Black, and all the other races combined accounted for 12% (n=4) (3% API, 6% AI/AN, and 3% multi-race) of the total newly diagnosed HIV infections in Washoe County.

FIGURE 28

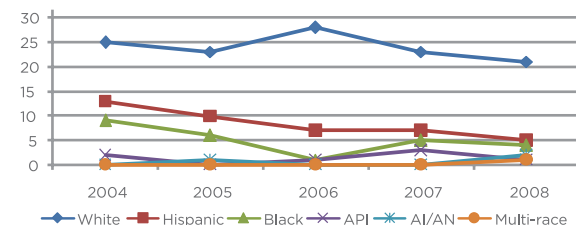
Percent of new HIV infections in Washoe County, Nevada by race/ethnicity: 2008



From 2004 to 2008, the number Whites living with HIV/AIDS increased 31%, while the number of Blacks increased 41%, Hispanics 33%, API 78%, and AI/AN 17% in Washoe County.

FIGURE 29

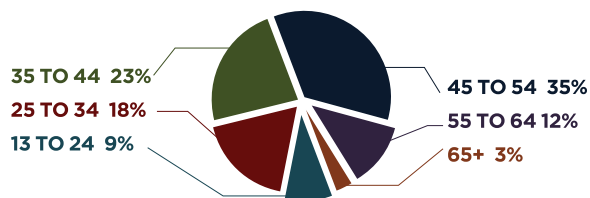
Number of HIV infections in Washoe County, Nevada by race/ethnicity: 2004-2008



Among new HIV infections, there was a decrease in all racial/ethnic groups in Washoe County in 2008. Whites experienced a 16% decline in number of new HIV infections while Hispanics decreased 62%, Blacks decreased 56%, API decreased 50% and there were no changes among AI/AN and those who identified as multi-race.

FIGURE 30

Percent of new HIV infections in Washoe County, NV by age at diagnosis: 2008



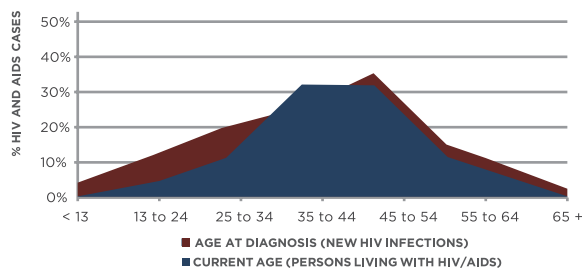
The proportion of new HIV infections in 2008, in Washoe County, was greatest among 45-54 year olds (35%, n=120) and 35-44 year olds (23%). There were no new cases among individuals less than 13 years of age. Yet youth

(13-24) accounted for 9% of the new HIV infections and young adults accounted for 18%. Older adults, those 55-64 and 65 and older accounted for 12% and 3% respectively.

From 2004 to 2008, among newly diagnosed HIV infections, 55-65 year olds experienced the greatest annual percentage growth of 33% followed by individuals 55 and older. There were declines among all other age groups.

From 2004 to 2008, the number of new HIV infections among 13-24 year olds decreased 57%, those 25-34 also decreased 57%, and 35-44 year olds decreased 50% in Washoe County. Although there were the most significant declines among younger individuals, they still make up the burden of the disease in Washoe County.

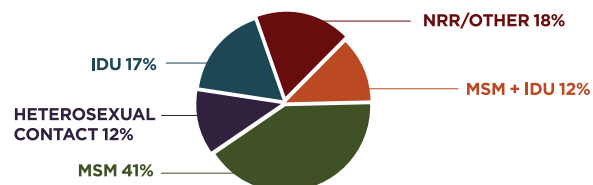
FIGURE 31
Number of persons living with HIV/AIDS by age at diagnosis compared to current age in Washoe county, Nevada : 2008



Comparing the age of newly diagnosed cases and the current age of persons living with HIV/AIDS in Washoe County, shows that peak of the newly diagnosed cases is in the older age group (45-54) compared to the majority of persons living with HIV/AIDS in Washoe County, whom are between 35-54 years of age.

Additionally, there are a greater number of new HIV infections among the youth and young adults compared to the living cases in Washoe.

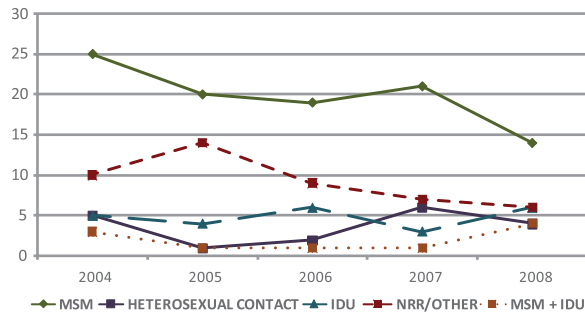
FIGURE 32
Percent of new HIV infections in Washoe County, Nevada by risk of transmission: 2008



Male to male sexual contact (MSM) was the most prevalent primary risk factor, accounting for 41% of the persons with new HIV diagnoses in Washoe County, Nevada in 2008. Injection drug use (IDU) was the second most commonly reported primary risk factor among new HIV infection in Washoe County, accounting for 17% of the total; followed by, heterosexual contact (12%); and, a combined risk of MSM and IDU (12%).

FIGURE 33

Trend in the number of new HIV infections in Washoe County, Nevada by risk factors of transmission: 2004-2008



Cases with no reported risk (NRR) or risk unknown accounted for 18% of new HIV infections in Washoe County in 2008. In 2004, 51% of new HIV cases were among

MSMs and in 2008, 41% had this risk factor, with a 44% annual decline in cases with MSM as primary risk factor for HIV infection.

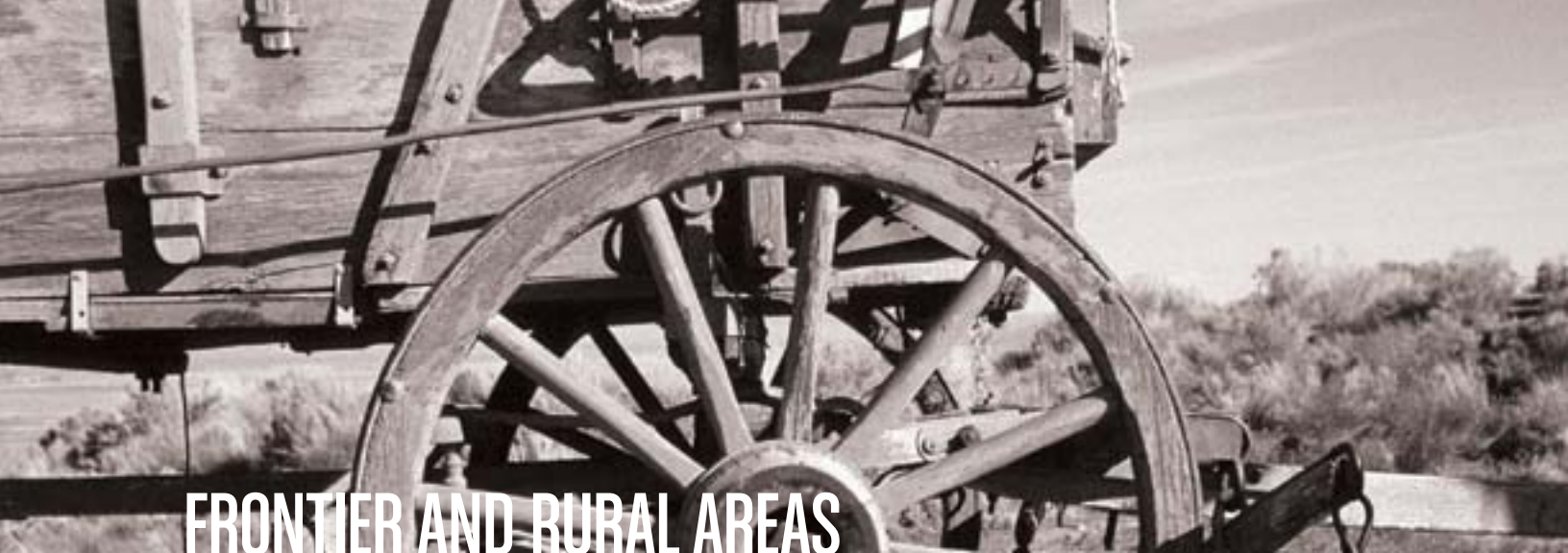
Among new HIV cases in Washoe County in 2008, IDU was reported as the primary risk factor for six of the new HIV infections in 2008 which was a 20% increase from the five cases in 2004 with this reported risk factor.

Heterosexual risk experienced a 20% decrease in the number of new HIV infections from five cases in 2004 to four cases in 2008 who reported this as the primary risk factor for acquiring HIV infection. Persons with this dual risk accounted for 3% in 2004 and 4% in 2008 of the total new HIV diagnoses.

TABLE 5

New HIV and AIDS diagnosis and persons living with HIV/AIDS in Washoe County, Nevada by demographics and risk factors

SEX	AIDS		HIV INFECTIONS		LIVING WITH HIV/AIDS	
	N	%	N	%	N	%
Male	21	88%	26	76%	683	85%
Female	3	13%	8	24%	122	15%
TOTAL	24	100%	34	100%	805	100%
RACE/ ETHNICITY						
White	13	54%	21	62%	540	67%
Black	6	25%	4	12%	106	13%
Hispanic	2	8%	5	15%	122	15%
API	1	4%	1	3%	16	2%
AI/AN	2	8%	2	6%	14	2%
Multi-race	0	0%	1	3%	7	1%
TOTAL	24	100%	34	100%	805	100%
AGE AT DIAGNOSIS						
<13	0	0%	0	0%	3	0%
13 to 24	0	0%	3	9%	71	9%
25 to 34	5	21%	6	18%	264	33%
35 to 44	5	21%	8	24%	314	39%
45 ti 54	10	42%	12	35%	120	15%
55 to 64	3	13%	4	12%	27	3%
65 +	1	4%	1	3%	6	1%
TOTAL	24	100%	34	100%	805	100%
RISK FACTOR						
MSM	12	50%	14	41%	423	0%
Heterosexual contact	0	0%	4	12%	76	9%
IDU	5	21%	6	18%	87	11%
NRR/OTHER	4	17%	6	18%	126	16%
MSM + IDU	3	13%	4	12%	89	11%
Perinatal exposure	0	0%	0	0%	1	0%
Adult hemophilic/blood transfusion	0	0%	0	0%	3	0%
TOTAL	24	100%	34	100%	805	100%



FRONTIER AND RURAL AREAS

The Frontier and Rural (FaR) areas of Nevada account for 10.7 percent of the state population, but 86.9 percent of the state land mass, illustrating the challenges of serving these residents.

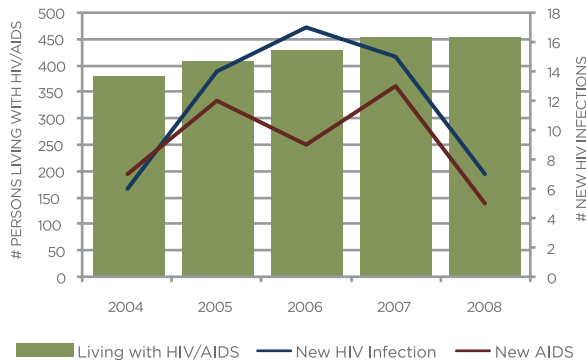
In Nevada, Carson City, Storey, Lyon, and Douglas counties are considered rural, and the remainder are considered frontier. Frontier area designation is defined as 7 persons or less per square mile. Nye County, located in the southern region of the state, is the third largest area county in the continental United States and has only 2.3 persons per square mile.

Most of Nevada's rural and frontier communities are located a considerable distance from the state's major health centers in the urban areas of the state. This distance makes it difficult for not only the residents to seek HIV services but for prevention and control staff to track and follow-up with new cases.

Due to the small sample size of new HIV infections in the FaR areas of Nevada, this section of this report will only report on persons living with HIV/AIDS for demographic and risk break down analyses.

FIGURE 34

Trend in the number of new HIV infections in Washoe County, Nevada by risk factors of transmission: 2004-2008



LIVING WITH HIV AND AIDS₂

In 2008 there were 470 persons living with HIV/AIDS in the Frontier and Rural (FaR) areas of Nevada, which accounted for 6% of the total number of persons living with HIV/AIDS in Nevada. In the FaR counties of Nevada, from 2004 to 2008 the number of persons living with HIV/AIDS has increased 20% from 391 in 2004 to 470 in 2008. The prevalence rate of persons living with HIV/AIDS in FaR in 2008 was 193 cases per 100,000 population.

NEW HIV INFECTION AND AIDS

In 2008, there were seven new HIV infections in the FaR counties of Nevada; representing a 17% increase from 2004. The seven new HIV infections accounted for only 2% of the total

new infections in Nevada. The cumulative incidence rate of new HIV infection in the FaR counties in Nevada in 2008 was eight per 100,000 population. From 2005 to 2006, there was a significant increase in the number of new HIV and AIDS cases in FaR, followed by a decline in 2007 to 2008. This could be due to an increase in testing in these areas.

1.NOT AIDS 2.HIV/AIDS

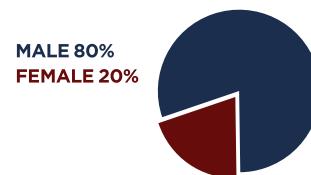
TABLE 6

Rate per 100,000 of persons living with HIV/AIDS and new HIV infections in FaR, Nevada: 2008

COUNTY	NEW HIV INFECTIONS	PERSONS LIVING WITH HIV/AIDS
Carson	1.7	310.8
Storey	0	228.2
Mineral	0	181.8
Pershing	0	180.7
Nye	1.2	149.9
Churchill	0	140.9
Lincoln	0	114.9
Douglas	3.8	113.2
Lyon	0	100.3
White Pine	10.3	72.2
Elko	2	37.6
Lander	0	33.9
Humboldt	0	17.7
Esmeralda	0	0
Eureka	0	0
TOTAL	2.1	139.9

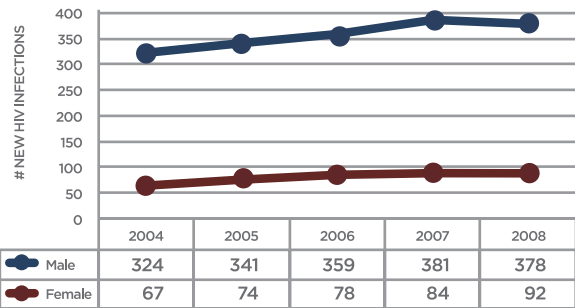
FIGURE 35

Percent of persons living with HIV/AIDS in FaR, Nevada by sex: 2008



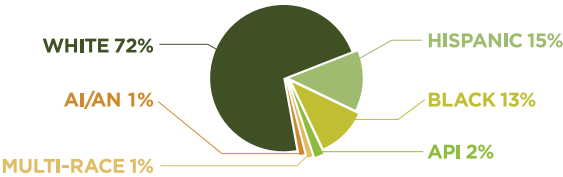
In 2008, in FaR, 80% (n=198) of new persons living with HIV/AIDS were among males and 20% (n=51) of the persons living with HIV/AIDS were among females.

FIGURE 36
Trends of persons living with HIV/AIDS in FaR, Nevada by sex: 2004-2008



From 2004 to 2008, the number of persons living with HIV/AIDS in FaR was on the upward trend for both males and females. Among males, there were 342 males living with HIV/AIDS in FaR areas and in 2008 there were 378; representing a 17% annual increase. Among females, there were 67 females living with HIV/AIDS in FaR areas and in 2008 there were 92; representing a 37% annual increase.

FIGURE 37
Percent of persons living with HIV/AIDS in FaR, Nevada by race/ethnicity: 2008

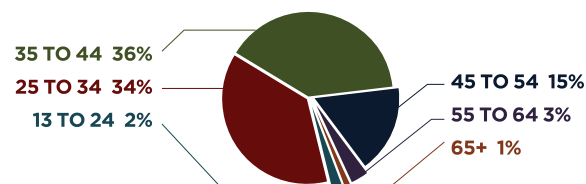


In 2008, among persons living with HIV/AIDS, the greatest proportion of cases were among White (72%) followed, Black (13%), Hispanics (11%), API (2%), and 2% for AI/AN (1%) and multi-racial (1%).

Among persons living with HIV/AIDS from 2004 to 2008, there were slight increases among all racial/ethnic groups with the most notable among API (67% increase), AI/AN (43% increase), and Hispanics (33% increase).

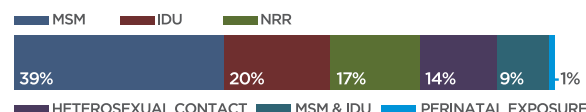
However, although there were increases among the number of cases, there was no increase in the proportion of cases for each racial/ethnic group.

FIGURE 38
Percent of persons living with HIV/AIDS in FaR, Nevada
by age at diagnosis: 2008



The proportion of persons living with HIV/AIDS was greatest among 35-44 (36%) and 25-34 year olds (34%). Those 45-54 years of age accounted for 15% of other persons living with HIV/AIDS, while 13-24 year olds accounted for 9%, 55-64 accounted for 3%, less than 13 year olds 2% and 65 and older 1%.

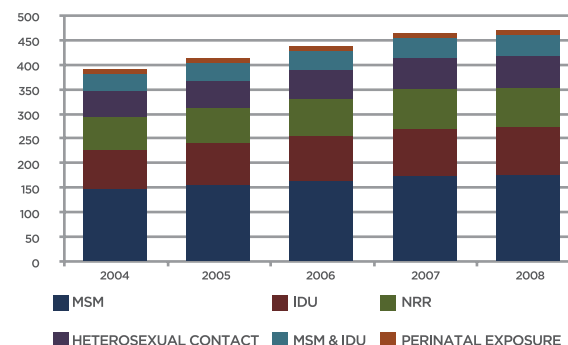
FIGURE 39
Percent of persons living with HIV/AIDS in FaR, Nevada
by risk factors of transmission: 2008



Male to male sexual contact (MSM) was the most common risk factor for persons living with HIV/AIDS in FaR. Primary risk of MSM accounted for 39%; followed by injection drug use (IDU) which accounted for 20% of primary risk factor, (NRR) or other risk unknown accounted for 17%, heterosexual contact accounted for 14% of

the total, combined MSM and IDU as primary risk factor accounted for 9%, and perinatal exposure accounted for 1% of persons living with HIV/AIDS in FaR in 2008.

FIGURE 40
Trend of persons living with HIV/AIDS in FaR, NV
by risk factors of transmission: 2004-2008

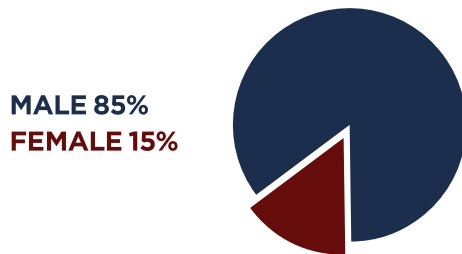


From 2004 to 2008, there was a 21% increase among MSM, 19% among IDU, 23% among heterosexual contact, 14% among those with a combined risk of MSM and IDU, and a 40% increase among those perinatally exposed in the persons living with HIV/AIDS in FaR areas of Nevada.

SEX OF HIV/AIDS CASES

FIGURE 41

Percent of new HIV infections in Nevada by sex: 2008



Consistent with national estimates in 2008, in Nevada the greatest proportion of new HIV infections were among males. Males accounted for 85% of new HIV infections and 83% of persons living with HIV/AIDS in Nevada in 2008.

The rate of new HIV infections among males is 26.7 cases per 100,000 population. Females accounted for 15% of new HIV infections and 17% of persons living with HIV/AIDS in Nevada in 2008. The rate of new HIV infections among males is 5.0 cases per 100,000 population.

Between 2004 and 2008, the number of new HIV infections among males increased 9% while the number of new HIV infections among females decreased 22% during this same time period.

New HIV infections among males were slightly older than females. For males, 30% (n=112) of the new HIV infections were among individuals 35-44 years of age compared to 30% (n=20) of females were 25-34 years of age. Overall, for both males and females the majority (57%) of new HIV infections were between 25-44 years of age. Males accounted for slightly more (15%, n=55) new HIV infections among youth (13-24) compared to females (13%, n=9).

FIGURE 42

Percent of new HIV infections in Nevada by risk factors of transmission among males: 2008



Females accounted for slightly more of the new HIV infections among older adults (55+) compared to males.

In 2008, 80% of males newly diagnosed with HIV had a primary exposure of male to male sexual contact (MSM), 7% were injection drug users (IDU), 6% were heterosexual contact, 5% combined exposure of MSM and IDU, and 2% had no reported risk or an unknown risk.

FIGURE 43

Percent of new HIV infections in Nevada by risk factors of transmission among females: 2008



There were no primary exposure of adult hemophiliac, blood transfusion, transplant, or perinatal exposure.

In 2008, 88% of females newly diagnosed with HIV had a primary exposure of heterosexual contact, 7% injection drug use (IDU), and 5% had no reported risk or an unknown risk.

Less than 1% had a perinatal exposure and there no primary exposure of adult hemophiliac, blood transfusion, or transplant.

MALE HIV HIGHLIGHTS 2008

- The rate of new HIV infection among males in Nevada in 2008 was 25.7 per 100,000.
- 85% of new HIV infections were among males.
- 47% of the new HIV infections were among Whites, followed by Hispanics (25%), and Blacks (23%).
- More than half (57%) of new HIV infections were among 25-34 year olds.
- The primary risk factor for new HIV infection was MSM (80%), followed by IDU (7%), heterosexual contact (6%), and MSM and IDU (3%).

FEMALE HIV HIGHLIGHTS 2008

- The rate of new HIV infection among females in Nevada in 2008 was 5.0 per 100,000.
- 15% of new HIV infections were among females.
- 45% of the new HIV infections were among Blacks, followed by White (30%), and Hispanics (23%).
- More than half (57%) of new HIV infections were among 25-34 year olds.
- The primary risk factor for new HIV infection was heterosexual contact (73%), followed by IDU (23%).

TABLE 7

Summary of HIV/AIDS among males in Nevada, by demographics and risk factor: 2008

COUNTY	AIDS		HIV INFECTIONS		LIVING WITH HIV/AIDS	
	N	%	N	%	N	%
Clark	217	89%	335	91%	5,539	84%
Washoe	21	9%	26	7%	683	10%
All other Counties	5	2%	7	2%	378	6%
Unknown County (NV)	0	0%	0	0%	17	0%
TOTAL	243	100%	368	100%	6,617	100%

RACE/ETHNICITY

White	107	44%	174	47%	3,755	57%
Black	56	23%	86	23%	1,338	20%
Hispanic	65	27%	91	25%	1,294	20%
API	11	5%	9	2%	151	2%
AI/AN	3	1%	4	1%	50	1%
Multi-race	1	0%	4	1%	29	0%
TOTAL	243	100%	368	100%	6,617	100%

AGE AT DIAGNOSIS

< 13	0	0%	0	0%	29	0%
13 -24	15	6%	55	15%	632	10%
25 - 34	54	22%	100	27%	2,393	36%
35 - 44	91	37%	112	30%	2,378	36%
45 - 54	56	23%	66	18%	926	14%
55 -64	21	9%	28	8%	220	3%
65 +	6	2%	7	2%	39	1%
TOTAL	243	100%	368	100%	6,617	100%

RISK FACTOR

MSM	197	81%	293	80%	4,751	72%
MSM & IDU	7	3%	19	5%	530	8%
Heterosexual contact	14	6%	21	6%	252	4%
IDU	18	7%	28	8%	542	8%
Perinatal exposure	1	0%	0	0%	28	0%
Adult Hemophilic/Blood	0	0%	1	0%	10	0%
NRR/NIR	6	2%	6	2%	504	8%
TOTAL	243	100%	368	100%	6,617	100%

TABLE 8

Summary of HIV/AIDS among females in Nevada, by demographics and risk factor: 2008

COUNTY	AIDS		HIV INFECTIONS		LIVING WITH HIV/AIDS	
	N	%	N	%	N	%
Clark	41	93%	59	88%	1,104	83%
Washoe	3	7%	8	12%	122	9%
All other Counties	0	0%	0	0%	92	7%
Unknown County (NV)	0	0%	0	0%	5	0%
TOTAL	44	100%	67	100%	1,323	100%

RACE/ETHNICITY						
White	13	30%	17	25%	553	42%
Black	20	35%	30	45%	523	40%
Hispanic	10	23%	16	24%	194	15%
API	0	0%	3	4%	29	2%
AI/AN	1	2%	0	0%	20	2%
Multi-race	0	0%	1	1%	4	0%
TOTAL	44	100%	67	100%	1,323	100%

AGE AT DIAGNOSIS						
< 13	0	0%	0	0%	31	2%
13 - 24	1	2%	9	13%	191	14%
25 - 34	11	25%	20	30%	472	36%
35 - 44	14	32%	18	27%	402	30%
45 - 54	10	23%	12	18%	164	12%
55 - 64	7	16%	7	10%	54	4%
65 +	1	2%	1	1%	9	1%
TOTAL	44	100%	67	100%	1,323	100%

RISK FACTOR						
Heterosexual contact	32	73%	59	88%	749	57%
IDU	10	23%	5	7%	277	21%
Perinatal exposure	0	0%	0	0%	27	2%
Adult Hemophilic/Blood	0	0%	0	0%	5	0%
NRR/NIR	2	5%	3	4%	265	20%
TOTAL	42	95%	64	96%	1,323	100%



WHITES

White, non-Hispanics continue to account for the majority of the HIV disease in Nevada. According to 2008 demographers interim population estimates.

Whites represented 62% of Nevada's total population and accounted for almost one-half (44%, n=120) of the 435 newly diagnosed HIV infections in Nevada in 2008. The rate of new HIV infections in Nevada among Whites was 11.2 cases per 100,000 Nevada residents.

From 2004 to 2008, the number of new HIV infections in Nevada among Whites decreased by 13%, while during the same time period there was a 20% increase in the number of Whites living with HIV/AIDS in Nevada. The number of new AIDS cases has remained relatively stable while also experiencing a downward trend.

Whites account for the greatest number and proportion of new HIV infections among all counties in Nevada; however, they do not necessarily account for the highest rates of new HIV infections in Nevada. Yet, the burden of disease in Clark County among Whites is alarming.

FIGURE 44
Number of persons living with HIV/AIDS and new HIV infections among whites in Nevada: 2004 -2008

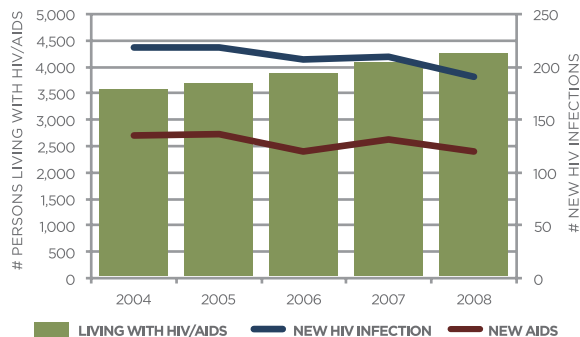
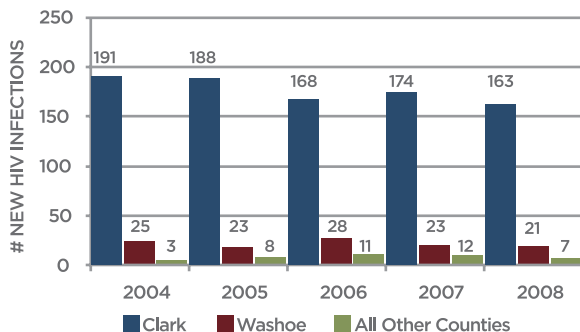


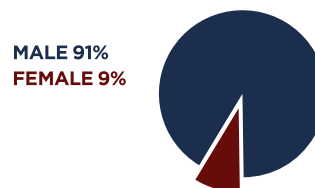
FIGURE 45
Number of new HIV infections among Whites by county of diagnosis in Nevada: 2004-2008



In 2008, 85% of the new HIV infections among Whites were in Clark, 11% in Washoe County, and 4% in all other counties combined.

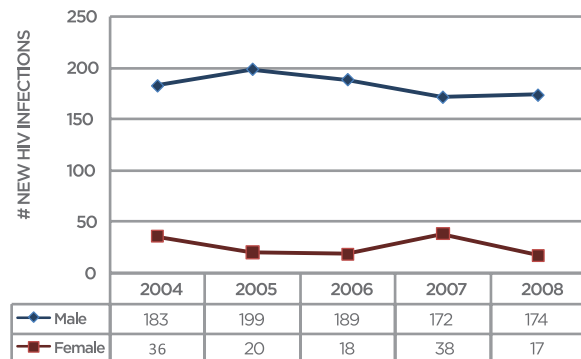
From 2004 to 2008, both Clark County and Washoe County experienced a slight decrease in the number of new HIV infections among Whites. For Clark County there was a 15% decrease and for Washoe County there was a 16% decrease; however, in all the other counties the number of new HIV infections among whites more than doubled.

FIGURE 46
Percent of new HIV infections among Blacks in Nevada, by sex: 2008



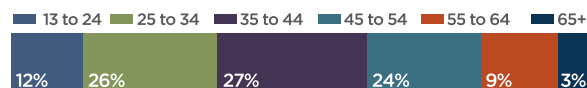
In 2008, a majority of the new HIV infections among Whites were male, 91%, while 9% were female. The rate of new HIV infections among White males was 20.3 per 100,000 population and females was 2.0 per 100,000 population.

FIGURE 47
Trends of new HIV infections among Whites in Nevada, by sex: 2004-2008



From 2004 to 2008, there were slight decreases in the number of new HIV infections among both White males and females but was more significant among males. In 2004, there were 183 new HIV infections among White males and in 2008 there were 174; this represents a 5% annual decrease. Among females there were 36 new HIV infections among White females in 2004 compared to 17 in 2008; this represents a 53% decrease in cases.

FIGURE 48
Percent of new HIV infections among Whites in Nevada, by age at diagnosis: 2008



Overall, half of the new HIV infections among Whites are among youth and young adults (13-34 year olds); however, upward trends over the past five years suggest that older White individuals are experiencing increases in new HIV infections in Nevada.

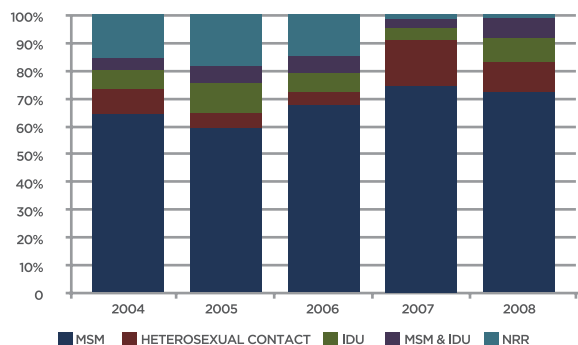
More than three-quarters of the new HIV infections among Whites in Nevada were between 25-54 years of age at time of diagnosis; 26% were 25-34, 27% were 35-44, and 24% were 45-54 years old. Although the greatest proportion of new HIV infections among Whites are among the younger individuals, the most notable increase was among individuals older than 45 years of age.

From 2004 to 2008, 45-54 year olds increased 12% annually, 55-64 increased 6% annually, and among the 65 and older age group increased 67% annually. During this same time period, the 25-44 age groups among Whites are on the decline; 36% annual decrease among 25-34 year olds and 11% decrease among 13-24 year olds.

12% annually, 55-64 increased 6% annually, and among the 65 and older age group increased 67% annually. During this same time period, the 25-44 age groups among Whites

are on the decline; 36% annual decrease among 25-34 year olds and 11% decrease among 13-24 year olds.

FIGURE 49
Percent of new HIV infections among Whites in Nevada, by age at diagnosis: 2008



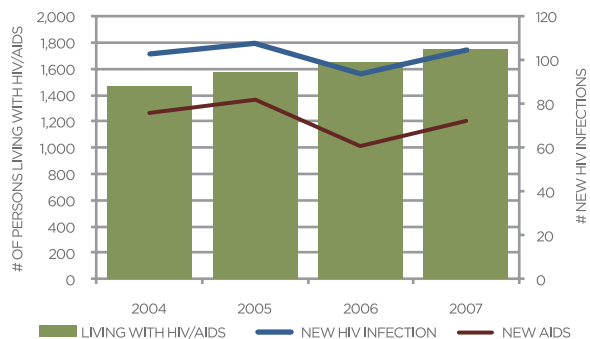
Almost one-half of the new HIV infections are among Whites, and they also account for the largest group of MSM in Nevada. The primary transmission risk for Whites in Nevada consistently has been MSM; accounting for 72% of the total new HIV infections among Whites in Nevada in 2008.

The number of Whites who reported Heterosexual contact increased 33% annually from 2004 to 2008 and accounted for 10% of the total risk for new HIV infections among Whites. IDU was reported as the primary risk for 9% of Whites and the combined risk of MSM and IDU

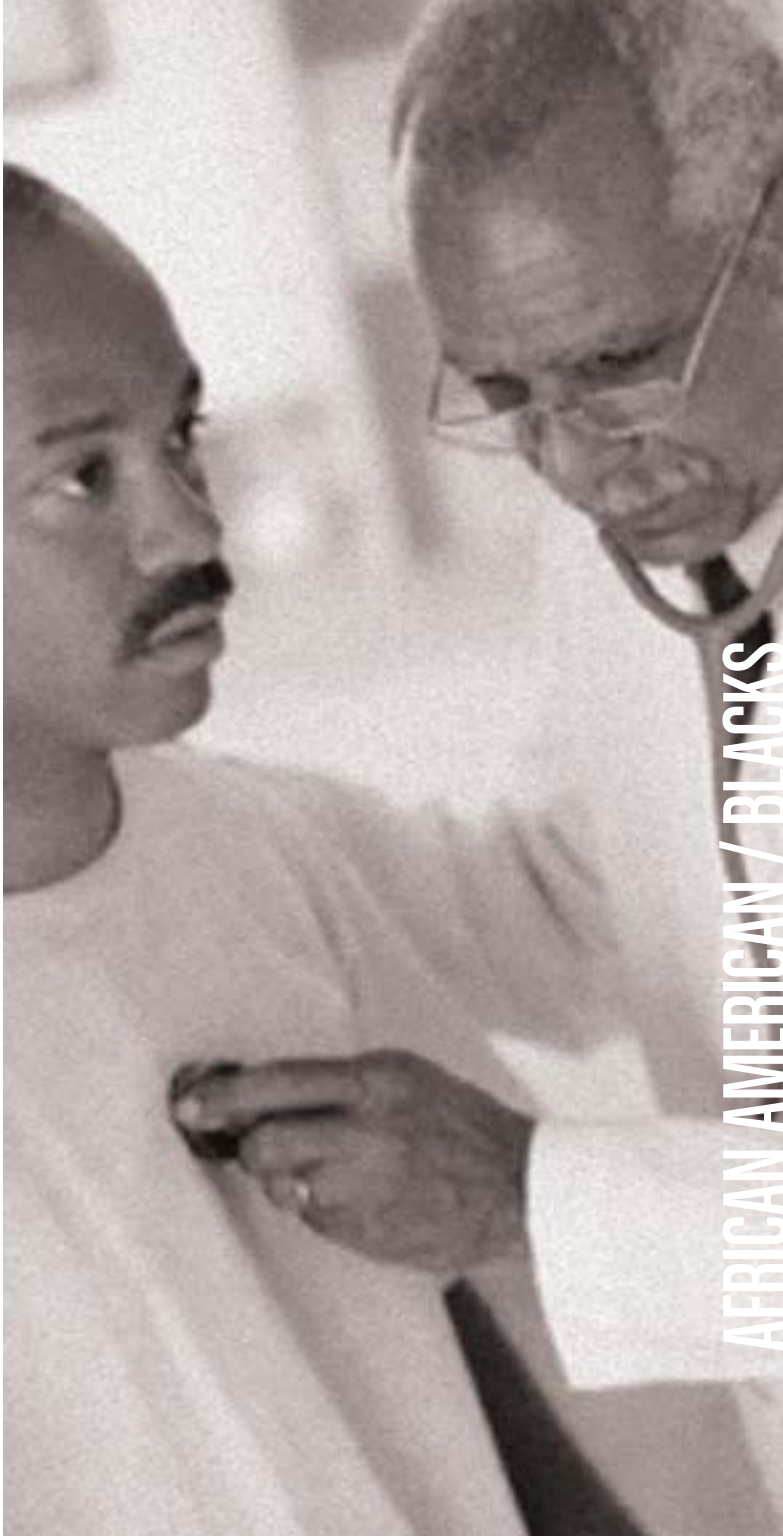
was reported for 7% in Nevada in 2008. Less than 2% reported either no risk (NRR/NIR) (1%).

The number of cases with no risk has decreased from 31 cases in 2004 to 2 cases in 2008; this is a result of improved interviewing by disease investigators.

FIGURE 50
Percent of persons living with HIV/AIDS and new infections among Blacks in Nevada: 2004 -2008



African Americans continue to be disproportionately affected by HIV infection both nationally and in Nevada. According to 2008 interim population estimates, African Americans represented only 7% of Nevada's total population; however, this group accounted for more than a quarter (27%, n=116) of the newly diagnosed HIV infections (N=435) in Nevada in 2008. The rate of new HIV infections in Nevada among Blacks was 62 cases per 100,000 Nevada residents.



AFRICAN AMERICAN / BLACKS

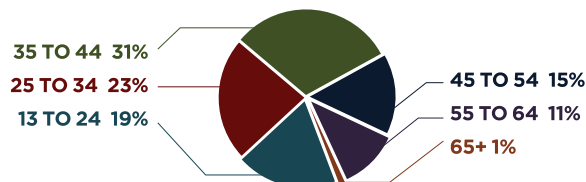
From 2004 to 2008, the number of new HIV infections in Nevada among Blacks increased by 13% while during the same time period there was a 28% increase in the number of Blacks living with HIV/AIDS in Nevada. The number of new AIDS cases has remained relatively stable between 2004 and 2008, with a slight decrease in new AIDS cases in 2006.

Within Nevada, there is a disproportionate amount of epidemic among this population in Clark County. Clark County has the highest percentage (9%) of African American residents in Nevada and accounted for 97% (n=112) of the 116 total new HIV infections among Blacks in 2008. The rate of new HIV infections for Clark County among Blacks was 3 cases per 100,000. From 2004 to 2008 Clark County experienced a 22% growth in number of new HIV infections among Blacks.

Although Washoe County only accounted for 4% of new HIV/AIDS cases among Blacks, the annual rate of HIV infection in 2008 was 1 per 100,000 among Blacks. From 2004 to 2008 the number of new HIV infections among Blacks declined from nine to four in 2008.

FIGURE 51

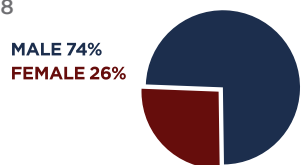
Percent of new HIV infections among Whites in Nevada, by age at diagnosis: 2008



In 2008, the greatest proportion of the new HIV infections among Blacks were 35-44 years of age followed by 23% being 35-34 years of age. Youth ages 13-24 accounted for 19% of the new HIV infections among Blacks, 15% were 45-54, 11% were 55-64, and about 1% were above 65 years of age at the time of HIV diagnosis.

FIGURE 52

Percent of new HIV infections among Blacks in Nevada, by sex: 2008



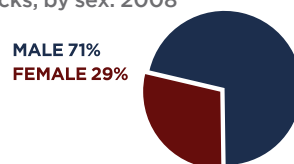
From 2004 to 2008, Blacks 55-64 and 25-34 years of age experienced the greatest percentage growth. Blacks 55-64 saw a 117% increase in the number of new HIV infections and Blacks 25-34 increased 35%.

Black men and women overall are disproportionately affected by HIV/AIDS in Nevada. Black males continue to dominate the epidemic, yet new HIV infections are rising

among females. In 2008 in Nevada, Black males accounted for 74% of the new HIV infections among Blacks and females accounted for more than a quarter of the new HIV infections (26%).

FIGURE 53

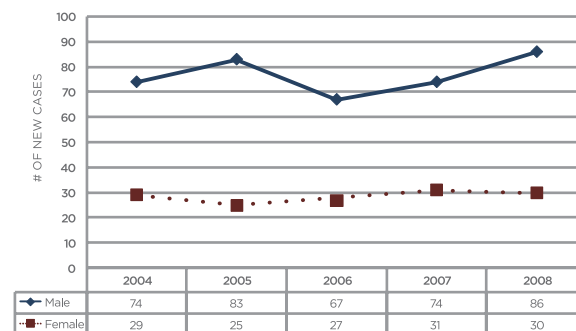
Percent of persons living with HIV/AIDS in Nevada among Blacks, by sex: 2008



Among Black persons living with HIV/AIDS in Nevada in 2008, 71% were among males and almost one-third (29%) were among females, which is a greater proportion compared to the number of new cases among all females.

FIGURE 54

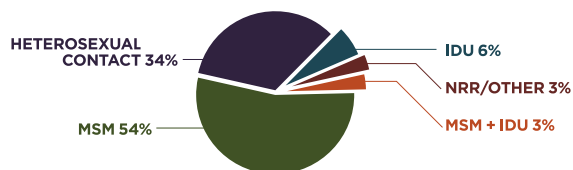
Trends of new HIV infections in Nevada among Blacks, by sex: 2004-2008



In Nevada, this disparity of HIV is most evident among Black males however; there is an upward trend in new HIV infections among

both Black males and females. From 2004 to 2008, Black males showed a 16% increase and Black females a 3% increase during this time period in Nevada.

FIGURE 55
Percent of new HIV infections among Blacks in Nevada, by risk of transmission: 2008



The most common risk factor for new HIV infections among Blacks in Nevada in 2008 was men who have sex with men (MSM) accounting for 54% (n=62) of the primary risk factors for HIV infection. Heterosexual contact was the second most common primary risk factor among Blacks, accounting for more than one-third of the new HIV infections.

Injection drug use (IDU) accounted for only 6% and co-occurring risk of MSM and IDU accounted for 3% of the primary risk factors among new HIV infections among Blacks in Nevada.

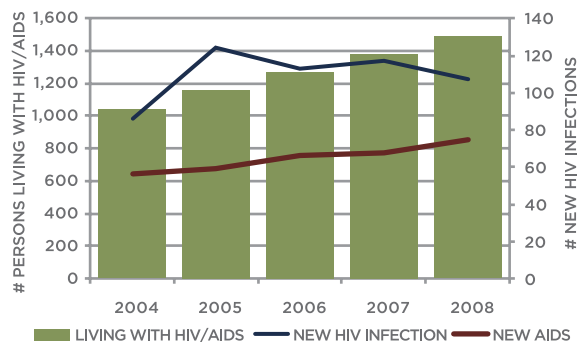
From 2004 to 2008, heterosexual contact among Blacks increased 63%. This is primarily due to increase among new HIV cases among Black females in Nevada. Additionally,

the risk of IDU among Blacks increased 36% from 2004 to 2008. During this same time period MSM as the primary risk factor for HIV decreased 44% and combined MSM and IDU doubled from two to four from 2004 to 2008, respectively. Hispanics continue to be disproportionately affected by HIV infection both nationally and in Nevada.

According to 2008 interim population estimates, Hispanics represented 39% of Nevada's total population and accounted for 25% (n=107) of the total newly diagnosed HIV infections (N=435) in Nevada in 2008.

In 2008, the rate of new HIV infections in Nevada among Hispanics was 10.1 cases per 100,000 Nevada residents.

FIGURE 56
Percent of new HIV infections among Blacks in Nevada, by risk of transmission: 2008





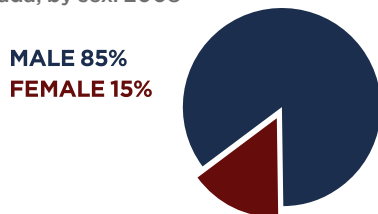
HISPANICS

From 2004 to 2008, the number of new HIV infections in Nevada among Hispanics increased by 24% while the number of newly diagnosed AIDS cases increased 34%. The number of Hispanics living with HIV/AIDS increased 44% during this same time period in Nevada.

Within Nevada, there is a disproportionate amount of epidemic among this population

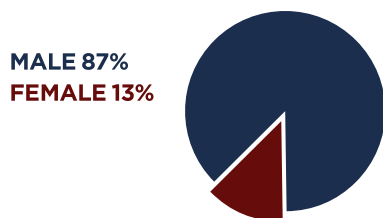
in Clark County. In 2008, 95% of the total new HIV infections among Hispanics were in Clark County and the remaining 5% in Washoe County. From 2004 to 2008, Clark County experienced a 40% growth in number of new HIV infections among Hispanics, while Washoe County had a 62% decrease from 13 cases in 2004 to 5.

FIGURE 57
Percent of new HIV infections among Hispanics in Nevada, by sex: 2008



Hispanic men and women overall are disproportionately affected by HIV/AIDS, in Nevada. Hispanic males continue to dominate the epidemic. In 2008 in Nevada, Hispanic males accounted for 85% of the new HIV infections while females accounted 15% of the cases.

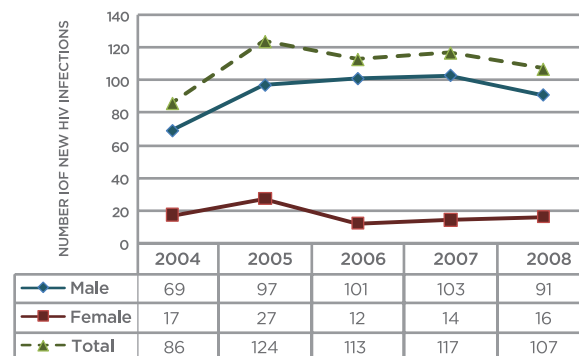
FIGURE 58
Percent of persons living with HIV/AIDS in Nevada among Hispanics, by sex: 2008



Among Hispanic persons living with HIV/AIDS in Nevada in 2008, 87% were among males and 13% were among females. Among both male and female Hispanics living with HIV/AIDS in Nevada, there were increases from 2004 to 2008. From 2004 to 2008, Hispanic males saw a 44% increase and Hispanic females saw a 46% increase. While there may

be a slight decrease in the number of Hispanic females infected with HIV, there is an increase in the number of females living with HIV/AIDS in Nevada.

FIGURE 59
Trends of new HIV infections in Nevada among Hispanics, by sex: 2008



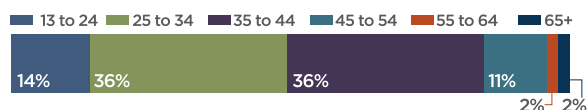
In Nevada, this disparity of HIV is most evident among Hispanic males however and there is an upward trend in new HIV infections. From 2004 to 2008, Hispanic males increased 32% from 69 new HIV infection cases in 2004 to 91 in 2008.

Among Hispanic females, there has been a decrease in this population in Nevada over the past five years. In 2004, there were 17 new HIV infections among Hispanics females and in 2008 there were 16; this represents a decrease of 6% percent. Although there has

been an overall decline in new HIV infections among females from 2004 to 2008, there was an increase from 2006 to 2008.

FIGURE 60

Percent of new HIV infections among Hispanics in Nevada, by age at diagnosis: 2008



Overall, half of the new HIV infections among Hispanics are among youth and young adults (13-34 year olds); 14% were 13-24 and 36% were 25-34. From 2004-2008 the number of new HIV infections among Hispanic youth (13-24) experienced the most notable increase; 10 cases in this group in 2004 to 15 cases in 2008, a 50% increase.

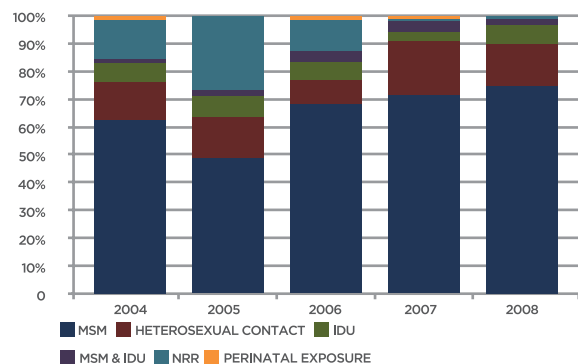
In 2008, 35-44 year olds accounted for 36% of the new HIV infections among Hispanics followed by 45-54 year olds (11%), 55-64 year olds (2%) and 65 and older (2%).

From 2004 to 2008, older adults (35-44) experienced a significant increase in number of cases in these age groups; 35-44 year olds increased 23%, while 45-54 year olds increased 33%. Consequently, there were decreases

among both the less than 13 year olds and 55 and older Hispanics.

FIGURE 61

Trends of new HIV infections among Hispanics, by risk of transmission: 2004-2008



The most common risk factor for new HIV infections among Hispanics in Nevada in 2008 was men who have sex with men (MSM) accounting for 75% of the primary risk factors for HIV infection. From 2004 to 2008 there was a 51% increase for MSM as a primary risk for HIV transmission among Hispanics.

Heterosexual contact was the second most common primary risk factor among Hispanics, accounting for more than 16% of the new HIV infections. From 2004 to 2008 there was a 42% increase for heterosexual contact as a primary risk for HIV transmission among Hispanics.

Injection drug use (IDU) accounted for 7%, combined risk of MSM and IDU accounted for 2%. From 2004 to 2008 there was a 17% increase for IDU as a primary risk for HIV transmission among Hispanics while there was no notable increase among those with a combined risk of MSM and IDU.

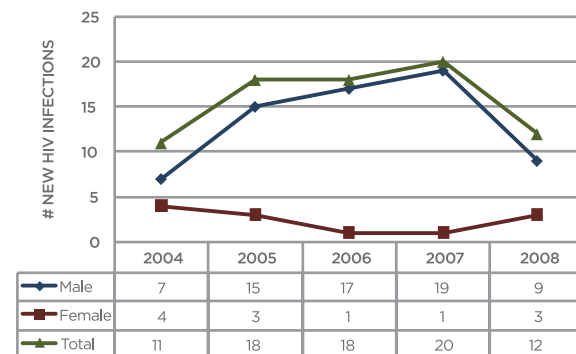
Perinatal exposure accounted for zero of the primary risk factors among new HIV infections among Hispanics in Nevada; this is down from 1% over the past several years.



In Nevada in 2008, 2% of the persons living with HIV/AIDS in Nevada were API. Additionally, 3% of the new HIV infections were among

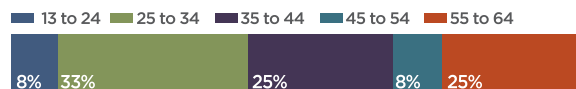
APIs, an increase of 9% from 2004 to 2008. Among the new HIV infections among APIs, 75% of the cases were diagnosed in Clark County and 25% in Washoe County.

FIGURE 62
Trends of new HIV infections among API, by sex:
2004-2008



In 2008, 75% of the new HIV infections among APIs were male and 25% were female. From 2004 to 2008, the number of new HIV infections among male APIs increased 29% while

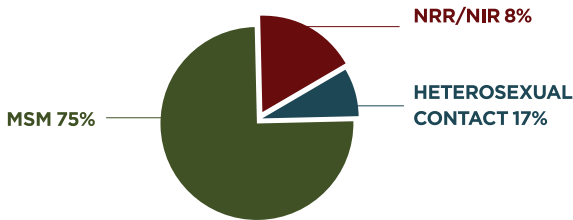
FIGURE 63
Percent of new HIV infections in Nevada among API,
by age at diagnosis: 2008



among female APIs decreased 25%. In 2008, the majority of the new HIV infections among APIs was in the 25-34 year old age group

FIGURE 64

Percent of new HIV infections in Nevada among API, by risk of transmission: 2008

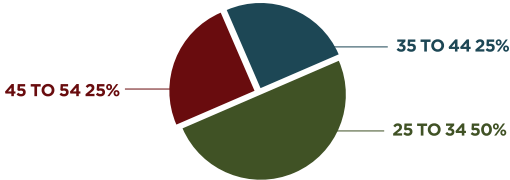


followed by 35-44 (25%), 55-64 (25%), and 13-24 (8%). From 2004 to 2008, the number of new HIV infections among 25-34 year olds doubled. Among the APIs in Nevada, 75% had a primary risk of MSM and 17% had a primary risk of heterosexual contact.



FIGURE 65

Percent of new HIV infections in Nevada among AI/AN, by age at diagnosis: 2008

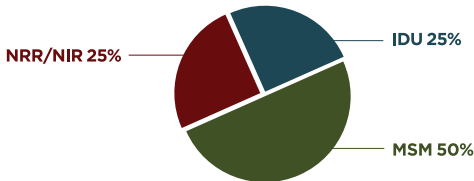


The risk of MSM among this group increased 50% from 6 cases in 2004 to 9 cases in 2008. In Nevada in 2008, 2% of the persons living with HIV/AIDS in Nevada were AI/AN and from 2004 to 2008 there was a 21% increase among this group.

Additionally, 1% of the new HIV infections were among AI/ANs and increased 33% annually from 2004 to 2008. Among the new HIV infections among AI/ANs, all of the cases were diagnosed in Clark County in 2008.

FIGURE 66

Percent of new HIV infections in Nevada among AI/AN, by risk of transmission: 2008



In 2008, the rate of new HIV infections among AI/ANs was 11.0 cases per 100,000 population. All of the new HIV infections among AI/ANs were male from 2006 through 2008. The rate of new HIV infections among males in Nevada, 2008 was 22.5 cases per 100,000 population. In 2008, of the new HIV infections among AI/ANs, half of the cases were between 25 to 34 years of age while the other half of the cases were between 35-54 years of age; 25% were between 35-44 and 25% were between 45-54 years of age.

Although in 2008 there were no cases among those 13-24 years of age, one-third of the cases from 2004 to 2007 were among this age group.

Among the AI/ANs in Nevada, 50% had a primary risk of MSM and 25% had primary risk of IDU. The remaining 25% of cases had no reported or identified risk.

These risk groups have remained consistent from 2004-2008. In Nevada, no cases have reported with heterosexual contact as a primary risk factor.



In the United States and in Nevada, the impact of HIV and AIDS on MSM is alarming. In 2008 in Nevada, for 60% of the persons living with HIV/AIDS in Nevada, MSM was the primary risk factor for HIV transmission.

Among persons living with HIV/AIDS in Nevada, from 2004 to 2008 there was a 30% increase among individuals with MSM as the primary risk factor for HIV transmission. From 2004 to 2008 the number of new HIV infections whose primary risk factor was MSM increased 11%.

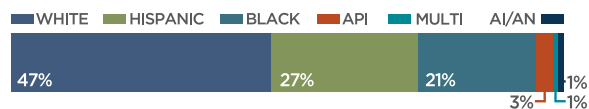
In Nevada, 95% of the new HIV infections whose primary risk was MSM were located in Clark County, 5% in Washoe County, and 1% in the FaR areas in 2008.

While the FaR areas represent only 1% of the new cases among this risk group, these areas of Nevada had a 33% increase from 2004 to 2008 among the number of new HIV infections whose primary risk was MSM; Clark County had a 17% increase; and, Washoe County experienced a 44% decrease in the number of new HIV infections whose primary risk was MSM.

The racial/ethnic distribution of the MSM risk group has consistently been primarily White (47%), yet from 2004 to 2008 there was a 6% decrease among Whites for the MSM risk group. Hispanics accounted 27% of the MSM risk group in 2008 and from 2004 to 2008 experienced a 51% increase.

FIGURE 67

Percent of new HIV infections in Nevada among MSM, by race/ethnicity: 2004 - 2008

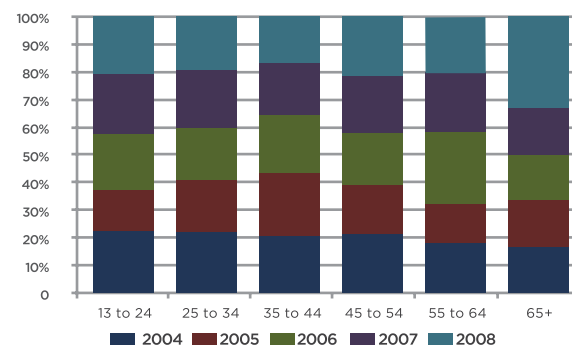


Blacks accounted for 21% of the MSM risk group and increased 11% from 2004 to 2008. APIs accounted for only 3% of the MSM risk group in 2008, yet from 2004 to 2008 experienced a 50% increase. AI/AN (1%) and those of multi-race (1%) represented only 2% of the MSM risk group in 2008.

In 2008, 16% of the new HIV infections among the MSM risk group were among youth 13-24 years of age. From 2004 to 2008, there was a 14% increase among this age group. The 25-34 (30%) and 35-44 year olds (29%) accounted for two-thirds (59%) of the new HIV infections among the MSM risk group.

FIGURE 68

Trends of new HIV infections in Nevada among MSM, by age at diagnosis: 2004 - 2008



From 2004 to 2008, the 25-34 year old group experienced a 26% increase; yet the 35-44 year olds experienced a 10% decrease during this same time period. The 45-54 year old age group accounted for 17% of the cases among the MSM risk group and increased 14% from 2004-2008. The older adults 55+ accounted for 8%, and the most significant annual increase. From 2004 to 2008, 55-64 year old MSM increased 50% while 65 and older individuals doubled.



13-24

YOUTH

Young people in the United States are at persistent risk for HIV infection. This risk is especially notable for youth of minority races and ethnicities.

Continual HIV prevention outreach and education efforts, including programs on abstinence and on delaying the initiation of sex, are required as new generations replace the generations that benefited from earlier prevention strategies. Unless otherwise noted, youth are persons who are 13-24 years of age.

In Nevada, the proportion of youth living with HIV/AIDS in 2008 was 15% of the total; moreover, the prevalence rate of persons living with HIV/AIDS between 13-24 was 175.0 per 100,000 population. Additionally, the rate of new HIV infections among this age group was 13.6 per 100,000 population. From 2004 to 2008 there has been a 12% annual increase in number of new HIV infections among youth in Nevada.

In 2008, the majority (94%) of the new HIV infections among youth were in Clark County and from 2004 to 2008 increased 20% in this area. In 2008, only 5% of the

new HIV infections were among youth in Washoe County and 2% were in the FaR areas of Nevada. Rate of new youth HIV in Clark County in 2008 was 18.0 per 100,000, Washoe County was 3.9 per 100,000, and in FaR areas of Nevada were 1.7 per 100,000 population among youth in Nevada in 2008.

Males accounted for 86% of the new HIV infections among youth in 2008 and females accounted for 14% of the cases. From 2004 to 2008, the number of new HIV infections among males increased 20% and the number of cases among females declined overall during the past five years; however, have been on the rise since 2006.

FIGURE 69
Number of new HIV infections in Nevada among youth (13-24), by sex: 2004 - 2008

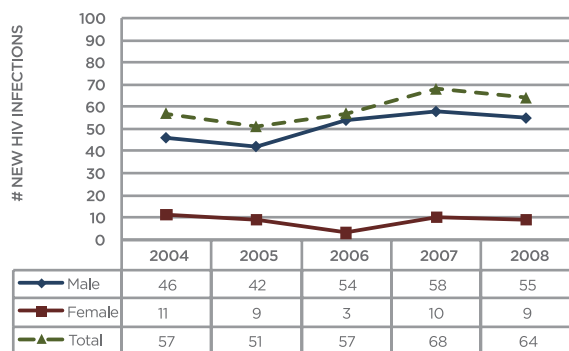
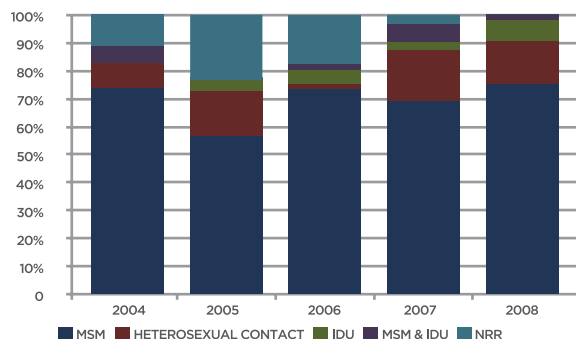


FIGURE 70
Percent of new HIV infections in Nevada among youth (13-24), by race/ethnicity: 2004 - 2008



Whites and Blacks each made up more than one-third (34%) of the new HIV infections among youth in Nevada; Hispanics accounted for 23% of the new HIV infections, those who identified as multi-race accounted for 6%, and APIs accounted for 2% in 2008. Hispanics experienced the greatest increase in number of new HIV infections among youth, from 2004 to 2008 there was a 50% annual increase among this group.

FIGURE 71
Trends of new HIV infections in Nevada among youth (13-24), by risk of transmission: 2004 - 2008



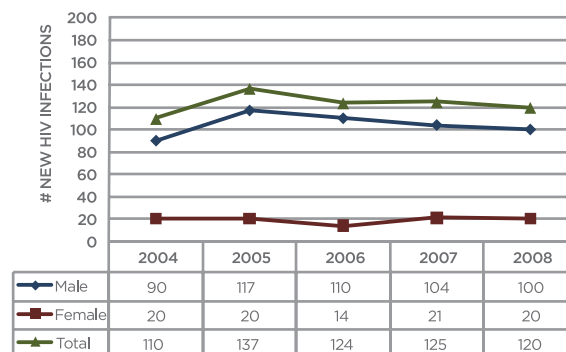
MSM has consistently been the primary risk for HIV infections among youth in Nevada, accounting for the risk of 75% of cases in 2008, and is continually increasing as a primary risk of HIV infection among youth. However, heterosexual contact has doubled from 2004 to 2008 and accounted for 16% of the new HIV infections. IDU accounted for 3% of new HIV infections, and trends for this risk among youth are declining. Combined risk of MSM and IDU accounted for 6% of the new HIV infections and from 2005 to 2008 has not seen change.

YOUNG ADULTS (25-34 YEAR OLDS)

Young adults include the age group 25-34 and accounted for more than one-third (28%) of the new HIV infections in 2008 in Nevada.

The rate of new HIV infections among this group was 29.9 per 100,000 population. Males accounted for 83% of the new HIV infections among this age group in 2008 and increased 11% from 2004 to 2008. Females

FIGURE 72
Trends of new HIV infections in Nevada among young adults (25-34), by sex: 2004 - 2008



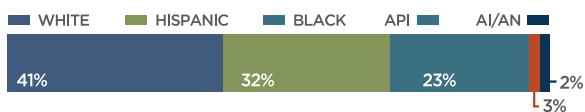
accounted for 17% of the new HIV infections among this age group in 2008 and saw no notable increase.

Among the 25-34 age group, 41% of the cases were White, 32% of the cases were Hispanic, 23% were Black, 3% were API, and 2% were AI/AN in Nevada in 2008. Both Blacks and Hispanics experienced increases. From 2004 to 2008, the number of new HIV infections among Black young adults increased 35% and Hispanics increased 195%.

The primary risk factors for transmission for young adults in 2008 was MSM (72%) and heterosexual contact (18%).

Both of these risk groups also experienced significant increases, MSM increased 26% and heterosexual contact as a primary risk factor increased 57%. IDU and the combined risk of MSM and IDU accounted for 3% and 5% of the mode of transmission for young adults, respectively.

FIGURE 73
Percent of new HIV infections in Nevada among young adults (25-34), by race/ethnicity: 2008



In Nevada in 2008, 8% of the new HIV infections, the primary risk of infection was IDU. There has been an increase in IDU as a primary risk of transmission in Nevada; from 2004 to 2008 there was a 6% increase.

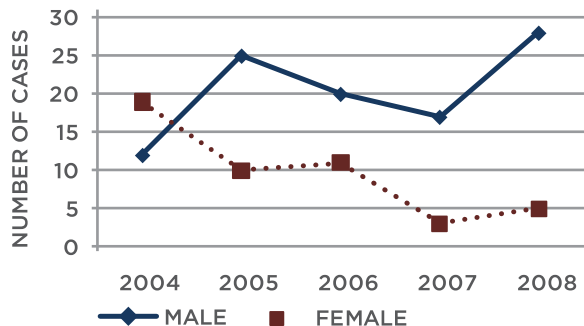
Among new HIV infections in Washoe County, which accounted for 18% of the IDU cases, IDU increased 20% from 2004 to 2008. Clark County, which accounted for 18% of the IDU cases, saw an 8% increase during this time period. In 2004, females accounted for a greater proportion (61%) of the IDU cases among new HIV infections; however, from 2004 to 2008 females saw a 74% annual decrease and males experienced a 133% increase.

In 2008, 85% of the new HIV infections whose primary risk was IDU were male. In 2008, over half (55%) of the new HIV infections whose primary risk was IDU were White, followed by 21% Black, 21% were Hispanic, and 3% AI/AN; there were no API.

Among all the racial/ethnic groups, Hispanics were the only group who experienced any notable change from 2004 to 2008. During

FIGURE 74

Trends of new HIV infections in Nevada among IDU, by sex: 2004 -2008



this time primary risk of IDU among Hispanics increased 17%. From 2004 to 2006, 35-44 year olds made up almost half of the cases of IDU; however, recent trends from 2007 to 2008, show that a decrease among that age group and an increase among 45-54 year olds, which in 2008 accounted for over one-third (36%) of the cases. Among 25-34 year olds, new HIV infections whose risk was IDU doubled from 6% of the cases in 2004 to 12% in 2008.

Additionally, 13-24 year olds and 55-64 year olds are seeing decreases during this same time period.

FIGURE 75

Percent of new HIV infections in Nevada among IDU, by race/ethnicity: 2008

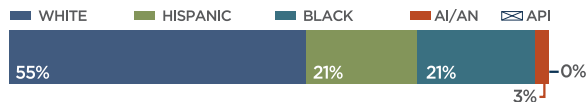
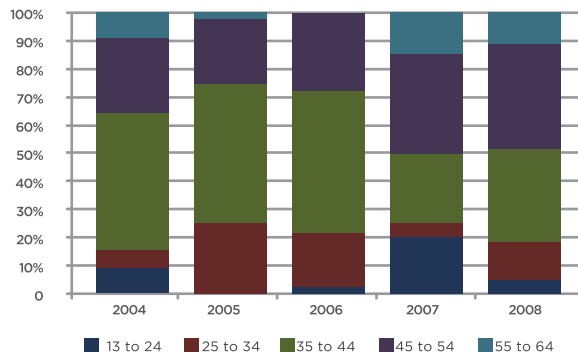


FIGURE 76

Percent of new HIV infections in Nevada among IDU, by age at diagnosis: 2004 - 2008



HIV/AIDS MORTALITY

Highly active antiretroviral therapy (HAART) was introduced in 1996. These medications have been effective in the treatment of HIV infection, and since that time have altered its natural progression.

HAART has delayed the progression from HIV to AIDS and from AIDS to death. Because of the widespread use of these HIV treatments, Nevada, along with the rest of the nation, has seen declines in the number of AIDS cases diagnosed as well as deaths. However, there is an estimated 14,500 deaths annually that are attributed to AIDS.

Memorials are important in remembering those who were affected and effected by this disease, and honor them through the annual AIDS memorial.



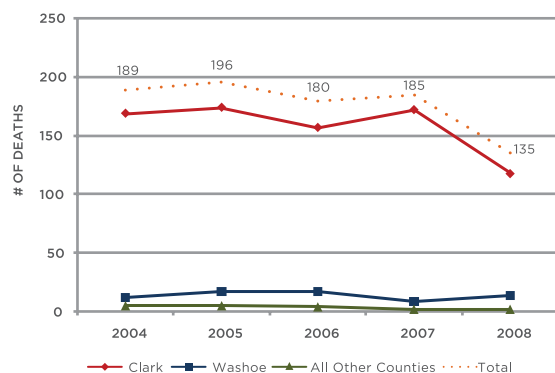


Photo by Mark Thiessen ©1992 The Names Project Foundation

each. In 2008, there were no new cases for this risk group among 13-24 year olds and 55-64 year olds; however, between 2004 and 2007, these age groups did have new HIV infections and are age groups that seem to fluctuate for this risk group. Deaths due to HIV/AIDS continue to be among the top ten leading causes of death in the U.S. for individuals 15-54. According to the Kaiser Family Foundation, the age-adjusted death rate for HIV disease was 2.9 in Nevada compared to 4.0 in the nation, ranking Nevada 29th in the nation.

FIGURE 77

Number of deaths among HIV/AIDS cases in Nevada, by County: 2004 - 2008

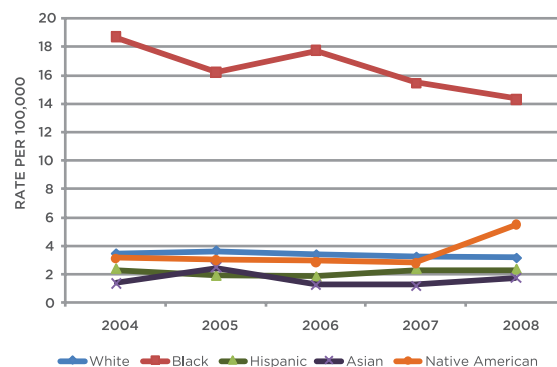


In Nevada, the number of deaths (not necessarily due to HIV or AIDS) among persons with HIV/AIDS has remained relatively stable

from 2004-2007; however, in 2008 there was a 26% decline in the number of deaths. This may be due to delayed reporting of deaths and a true decline in deaths. There continues to be racial disparities in the rates of deaths among individuals with HIV/AIDS in Nevada. In 2008, although the number deaths were greatest among Whites, the rates of death were highest among Blacks. This could be due to cultural differences in testing and care. It has been shown that Blacks test later in their disease, as well as being disproportionately affected by many other health disparities.

FIGURE 78

Rate per 100,000 of all deaths among HIV/AIDS cases in Nevada, by race/ethnicity: 2004 - 2008



SECTION FOUR

COMMUNITY SERVICES ASSESSMENT

The Northern Nevada Planning Council and the Community Planning Group of Southern Nevada gathered information about HIV prevention service needs, available resources, and approaches that are being used to address those needs.

Key questions included:

- Which populations are being served?
- Which populations are not being served?
- Which populations are hardest to reach?
- What key behaviors are placing individuals at risk for HIV?
- What barriers exist that prevent individuals from protecting themselves against HIV?
- Which HIV prevention services in the community are effective?
- Which HIV prevention services do individuals need that are not available or accessible?

The community services assessment attempts to answer these questions while creating a picture of the HIV prevention needs in Nevada and serving as a guide for identifying and setting HIV prevention priorities.

The community services assessment is comprised of three key parts:

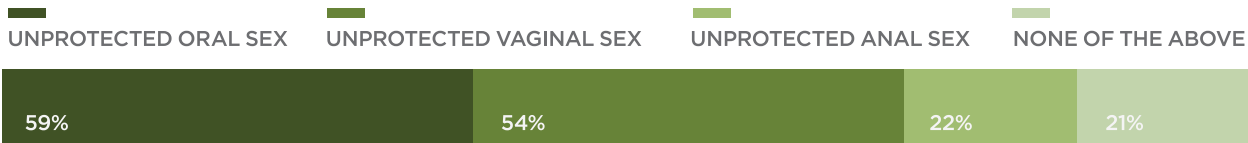
- Needs Assessment
- Resource Inventory
- Gap Analysis

PART ONE | NEEDS ASSESSMENT

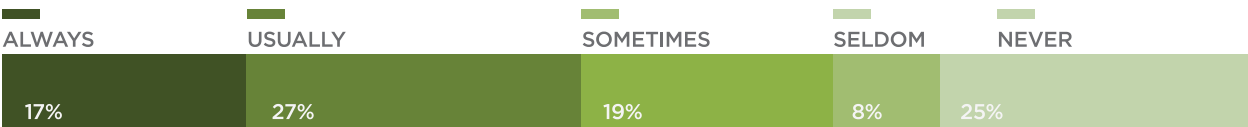
- 664 Key Informant Surveys were conducted statewide that collected quantitative information about HIV risks, barriers to prevention, and community needs.
- 96 MSM Risk Behavior Surveys were conducted statewide that collected quantitative information about HIV risks, barriers to prevention, and community needs specific to the MSM population.
- 22 Focus Groups with 194 total participants were conducted statewide that collected qualitative information about HIV risks, barriers to prevention, and community needs, specific to populations disproportionately infected and affected by HIV/AIDS.
- Key data from the Key Informant Surveys, MSM Risk Behavior Surveys, and Focus Groups is listed below.
- Recommendations from the Needs Assessment have been incorporated into Section Six: HIV Prevention Goals, Interventions, and Strategies.

A. KEY INFORMANT SURVEY DATA

Condom use in the past 12 months when you had sex (oral, vaginal, anal).



Frequency of condom use in the past 12 months during sex (oral, vaginal, anal).

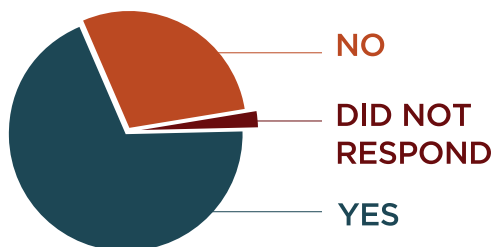


REASONS FOR NOT USING CONDOMS	% OF RESPONSES
Only have sex with ONE person	43%
Other	13%
Don't Like Feeling	13%
Ruin Moment/inconvenient	8%
No Sex past 12 Months	7%
Did not Respond	6%
Persons Refuses to Use	3%
Uncomfortable to talk about	3%
Can't Afford	2%
Total Number of Responses	100%

Needle sharing behavior among the respondents (n=21) who injected drugs in the past 12 months.

NEEDLE SHARING BEHAVIOR IN PAST 12 MONTHS	%
SHARED NEEDLES/WORKS W/O BLEACHING	24%
SHARED NEEDLES FOR TATTOOS/PIERCING	0%
SHARED COOKER, COTTON, RINSE WATER	10%
NONE OF THE ABOVE	67%

Have you ever been tested for HIV
(even results were not obtained)?



PREFERRED PLACE TO SEEK HIV/AIDS INFORMATION	% OF REPOSES
Internet	30%
Health Department	22%
Health Care Providers	19%
Friends	9%
Family	8%
Sexual Partner(s)	6%
Teacher	4%
Church	2%
Other	2%
Total Number of Responses	100%

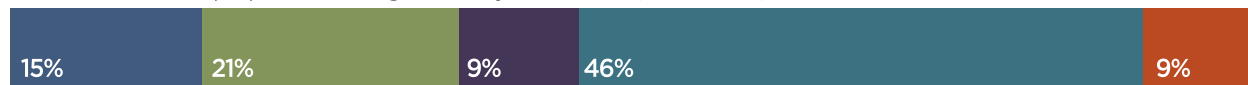
RESPONSES FOR NOT GETTING A HIV TEST	% OF REPOSES
I have not been exposed to HIV	29%
I never really thought about getting tested	25%
I thought I was HIV negative	11%
I did not know where to get tested in the area	10%
I was afraid of finding out I am HIV positive	9%
Cost	8%
I was worried my name would be reported to government	4%
Takes too much time	2%
Inconvenient location	2%
Total Number of Responses	100%

PREFERRED METHOD OF RECEIVING HIV/AIDS INFORMATION	% OF REPOSES
Internet	22%
Health Care Providers	14%
Brochures	10%
Community Agency	10%
Friends/Family/Partners	9%
TV	9%
Community Events	7%
Newspaper Ads/Billboards	6%
Teacher	6%
Radio	5%
Church	4%
Total Number of Responses	100%

Community Opinions

STRONGLY AGREE
SOMEWHAT AGREE
SOMEWHAT DISAGREE
STRONGLY DISAGREE
NO RESPONSE

Medical care can help a person live longer and stay healthier if he/she has HIV/AIDS.



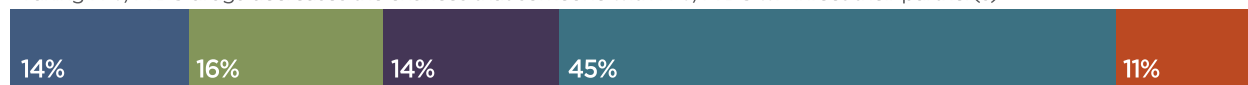
My sexual partners and/or needle sharing partners are genuinely concerned with whether I have had an HIV test and what the results were.



I see HIV/AIDS as a manageable/treatable disease and am not as concerned about getting it.



Taking HIV/AIDS drugs decreases the chances that someone with HIV/AIDS will infect their partner(s).



Oral sex without a condom is safe if there is no ejaculation (cum).



Anal Sex without a condom is safe if there is no ejaculation (cum).



Sometimes I do not use condoms because they require too much effort.

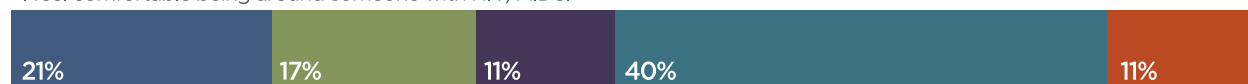


STRONGLY AGREE
SOMEWHAT AGREE
SOMEWHAT DISAGREE
STRONGLY DISAGREE
NO RESPONSE

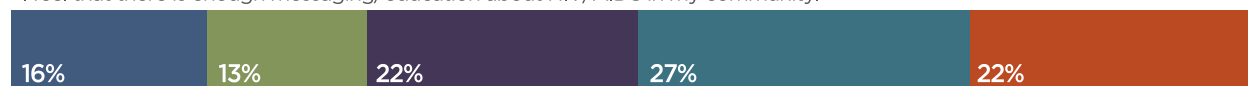
I feel that people who were infected with HIV/AIDS through sex or drug use got what they deserved.



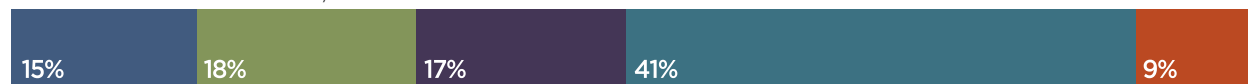
I feel comfortable being around someone with HIV/AIDS.



I feel that there is enough messaging/education about HIV/AIDS in my community.



I would date someone with HIV/AIDS.



HIV/AIDS affects my life.



I am concerned about getting HIV/AIDS.



I know where to get an HIV/AIDS test.



B. MSM RISK BEHAVIOR SURVEY DATA

METHODOLOGY

Participants in the MSM focus groups (N=96) also completed an anonymous quantitative survey that assessed demographics, sexual and drug risk behaviors, and HIV testing history. Because little is known about use of the internet and HIV risk among MSM in Nevada, sexual behavior questions were asked separately for partners met online and those met offline. In addition, patterns of internet use (number of hours spent online per week and websites most commonly used) and attitudes about online HIV prevention were assessed.

RESULTS

Sexual Behaviors and Use of the Internet

Half the participants reported using the internet to meet sex partners during the past six months and 60% met partners offline (bars, clubs, friends, or organizations) (Figure 79). Over one fifth of MSM who used the internet to meet sex partners the past six months said they spend 10 hours or more searching for partners online each week (Figure 80).

FIGURE 79

Method of meeting sex partners

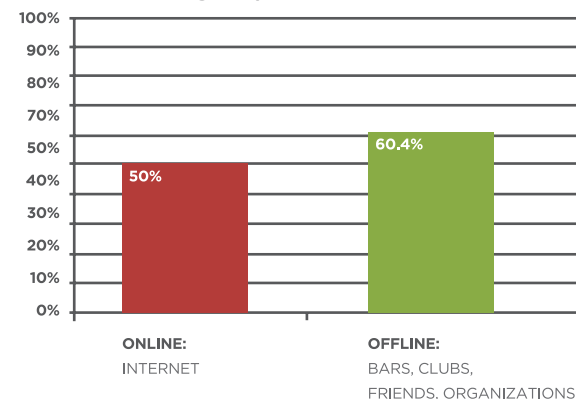


FIGURE 80

hours online per week searching for partners

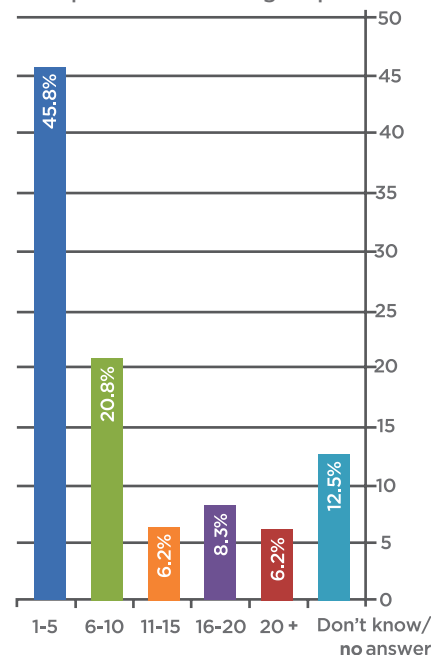
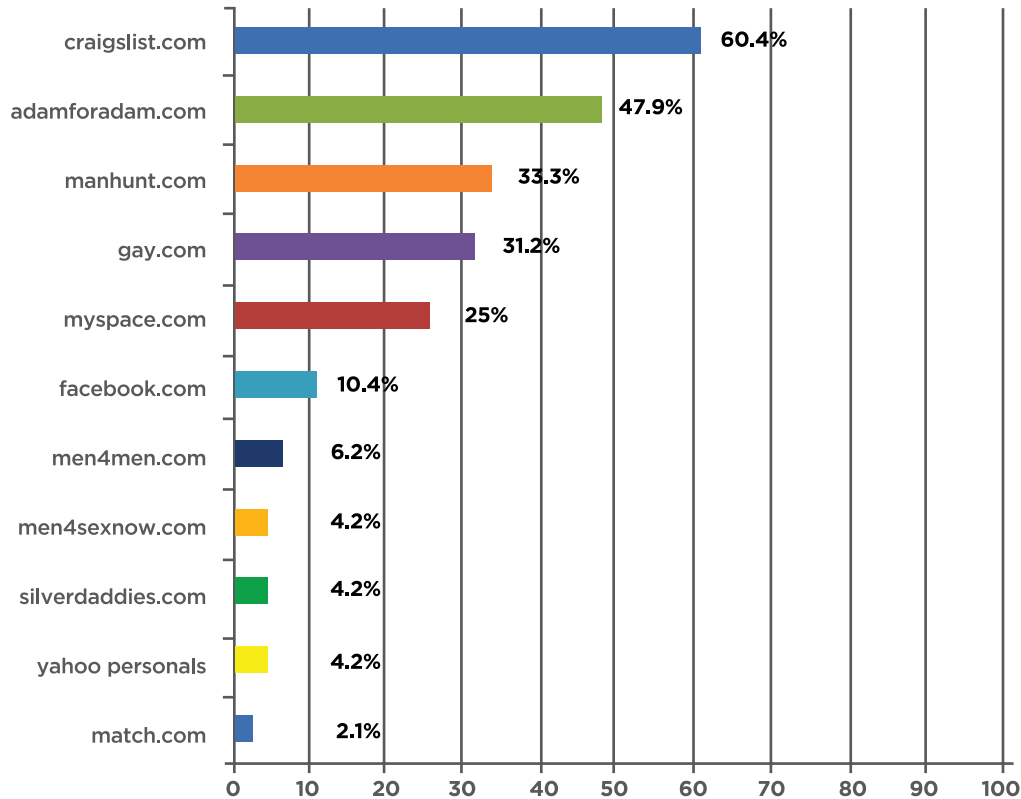


FIGURE 81

Websites used to search for partners (past 6 months)

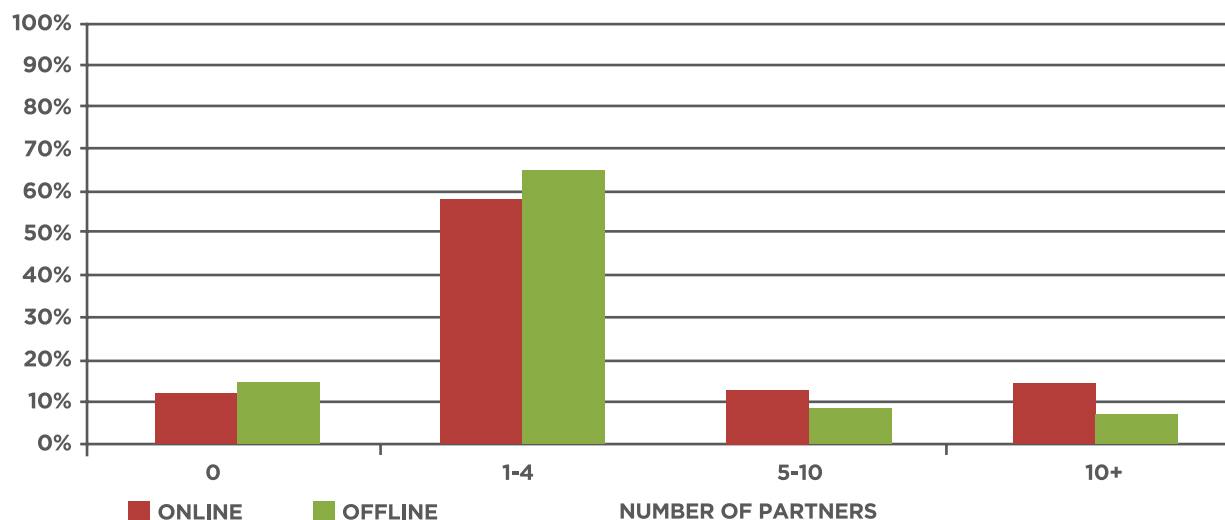


*Among MSM who reported using the internet to find online partners in past six months

As shown in Figure 5, the websites most commonly used to locate sex partners in the past six months included Craigslist.com (60%), Adamforadam.com (48%), manhunt.com (33%), gay.com (31%), and myspace.com (25%).

Overall, there were not large differences between in the number of partners that participants reported meeting online compared to offline during the past six months (Figure 79). However, consistent condom use was much less frequent when MSM had sex with online partners compared to offline partners: receptive anal sex (53% vs. 74%), insertive anal sex (54.5% vs. 69%), and oral sex (3% vs. 25.5%).

FIGURE 82
Number of partners (past 6 months)



Over half (58%) of participants believed that internet sites used to meet sex partners do not have enough HIV/STD information and 56% said that they would use a website for MSM who are only interested in having safe sex.

FIGURE 83
Consistent condom use (past 6 months)

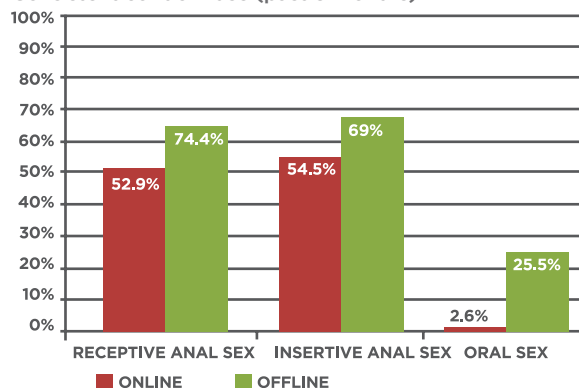
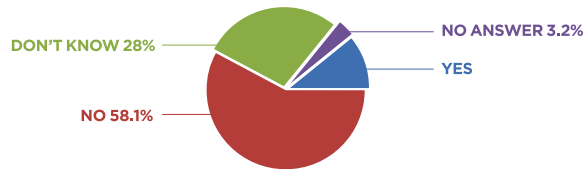
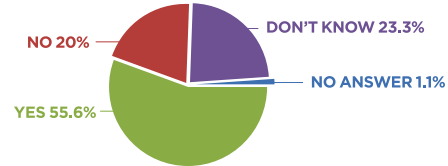


FIGURE 84

Do internet sites have enough std information?

**FIGURE 85**

Would you use a safe sex website?



C. FOCUS GROUP DATA

Recruitment

Twenty-two focus groups with 194 total participants were conducted in Northern and Southern Nevada (Table 9).

TABLE 9

Focus Group Recruitment

	Northern Nevada # participants per group	Southern Nevada # participants per group
MSM: 18-24 years	7	10
MSM: 25-44 years	6	9
MSM: 45 + years	8	6
MSM: African-American	8	10
MSM: Latino / Hispanic	7	8
MSM: HIV+	8	9
Youth (<=24)	10	12
Transgender	6	11
African-American Male	10	--
African-American Female	9	--
IDU	--	11
Commercial Sex Worker	5	--
Re-Entry	8	--
Substance Use	16	--

DATA COLLECTION

Collaboratively, the Northern Nevada HIV/AIDS Planning Council (NNPC) and the Community Planning Group of Southern Nevada Planning Group (CPG-SoN) developed a MSM focus group guide with six open-ended questions.

This guide was later adapted for focus groups with other populations. The focus group questions were designed to determine factors associated with HIV risk and to elicit recommendations for prevention.

Each focus group discussion was led by two trained facilitators. Before data collection began, the facilitators described the purpose of the needs assessment and the importance of maintaining participant confidentiality. The focus groups were digitally recorded and professionally transcribed; however, participant names were not used. Participants were assured that the recordings and transcripts would be destroyed after data analysis and report writing was complete and that personal identifiers would not be used in the report.

ANALYSES

Group facilitators and planning council members coded the focus group transcripts (2 per group). Thematic analyses were conducted to determine factors associated with HIV risk on three levels: 1) individual; 2) relationship; and 3) social. A matrix of HIV risk factors was created and risk factors were ranked on a scale from 1-5 (a higher score indicated greater importance and frequency of discussion in the group).

This allowed for the determination of themes that cut across all groups and as well as subgroup differences. Thematic analyses were also conducted to determine the most frequently recommended HIV prevention strategies.

FOCUS GROUP RESULTS

Factors that contribute to HIV risk

Thematic analyses identified factors associated with HIV risk on the individual, relationship, and social level. Tables 2 and 3 demonstrate how frequently each factor was discussed by focus group participants.

There were few differences in the findings based on geography; therefore, when focus groups were conducted in both Southern Nevada and Northern Nevada, the results were combined.

TABLE 10**Factors Associated with HIV Transmission (MSM)**

	18-24	25-44	45+	AA	Latino	HIV+	AVERAGE
INDIVIDUAL FACTORS							
Substance Use	4	5	5	4	5	5	4.7
Use of Internet	5	5	5	5	4	3	4.5
Hidden Identity	4	4	2	5	5	3	3.8
Survival Sex	4	3	1	1	1	0	1.7
RELATIONSHIP FACTORS							
Establishing Trust	3	4	4	4	0	0	3.2
Condom Negotiation	4	4	2	2	3	3	3.0
Unequal Power/Violence	2	3	4	1	0	0	1.7
SOCIAL AND COMMUNITY FACTORS							
Treatment Optimism	3	5	5	3	5	5	4.3
Social Apathy	3	3	3	3	3	4	3.2
Perceived Discrimination	0	1	4	4	4	3	2.5
Limited sense of Community	0	3	2	2	2	3	2.0

TABLE 11**Factors Associated with HIV Transmission (Vulnerable Populations)**

	Re-entry	Substance Use	AA	CSW	TG	Youth	IDU	AVERAGE
INDIVIDUAL FACTORS								
Low self-esteem/depression	4	3	3	5	5	4	5	4.1
Low condom appeal	4	3	3	5	1	5	3	3.4
Substance use	2	5	2	5	3	2	5	3.4
Survival sex	1	0	0	5	4	0	3	1.9
Hidden identity	0	0	0	0	2	0	2	0.6
Use of the internet	0	0	0	0	1	1	0	0.3
RELATIONSHIP FACTORS								
Establishing trust	1	2	0	3	0	4	4	2.0
Condom negotiation	0	0	0	3	0	4	3	1.4
Unequal power/violence	0	0	0	3	0	2	0	0.7
SOCIAL AND COMMUNITY FACTORS								
Perceived discrimination	3	5	4	2	4	1	5	3.4
Treatment optimism	3	1	1	3	1	4	5	2.6
Social apathy	2	4	3	1	1	1	4	2.3
Economic factors	2	0	1	4	4	0	0	1.6
Limited sense of community	0	2	2	0	5	0	0	1.3

PART TWO | RESOURCE INVENTORY

- A survey instrument was created to gather information for the resource inventory, which identified service providers for the HIV prevention needs of the state.
- Existing resource directories were utilized to identify service providers across the state to be surveyed.
- The survey collection tool was sent to providers throughout Nevada in an effort to assess existing services currently meeting HIV prevention needs.
- In total, 30 HIV prevention service providers were identified.
- Key data from the Resource Inventory is listed below.

HIV Prevention Center	A.C.C.E.P.T.	ACCESS TO HEALTHCARE	AID FOR AIDS OF NEVADA*	CARSON CITY HEALTH AND HUMAN SERVICES	CATHOLIC CHARITIES
Type of Service	GLI, HC/PI	RWC	ILI, GLI	ILI, GLI	ILI
Evidence Based Intervention	VOICES		Healthy Relationships		
HIV Testing	No	No	No	Yes	No
Target Population	African American	HIV+	ALL	ALL	ALL
Target Behavioral Risk Group	HIV+, Y/YA	HIV+	HIV+	HIV+	HIV+
Type of Agency	FBO	CBO	CBO	County	FBO
Region	North (Washoe, FaR)	State Wide	South (Clark)	North (Carson, Douglas, Lyon)	South (Clark)
Contact Information	580 W. 5th St, #1A Reno, NV 89503 (775) 786-5886	4001 S. Virginia St. #F Reno, NV 89502 (775) 284-8989 4530 S. Eastern Ave. #9 Las Vegas, NV 89119 (702) 489-3400 801 E. Williams Ave. Fallon, NV 89408 (775) 867-7029	701 Shadow Lane Las Vegas, NV 89106 (702) 382-2326	900 E. Long St. Carson City, NV 89706 (775) 887-2190	1511 N. Las Vegas Blvd Las Vegas, NV 89101 (702) 387-2291

HIV Prevention Center	COMMUNITY COUNSELING CENTER*	COMMUNITY OUTREACH MEDICAL CENTER	GAY AND LESBIAN COMMUNITY CENTER OF SOUTHERN NEVADA*	GOLDEN RAINBOW	NEVADA AIDS PROJECT
Type of Service	ILI, GLI	RWC	ILI, GLI, HC/PI	RWC	HC/PI, GLI
Evidence Based Intervention	Holistic Health Recovery		Mpowerment		
HIV Testing	No	No	No	No	No
Target Population	ALL (Latino)	ALL	ALL	ALL	ALL
Target Behavioral Risk Group	HIV+	HIV+	MSM, Y/YA	HIV+	HIV+
Type of Agency	CBO	CBO	CBO	CBO	CBO
Region	South (Clark)	South (Clark)	South (Clark)	South (Clark)	South (Clark)
Contact Information	1120 Almond Tree Ln #207 Las Vegas, NV 89104 (702) 369-8700	3603 N. Las Vegas Blvd #110 Las Vegas, NV 89115 (702) 657 3873	953 E. Sahara Ave, #B-31 Las Vegas, NV 89104 (702) 733-9800	3233 W. Charleston Blvd Suite 108 Las Vegas, NV 89102 (702) 384-2899	455 S. Grand Central Parkway, C-344 Las Vegas, NV 89106 (702) 636-1800

HIV Prevention Center	NEVADA HISPANIC SERVICES*	NEVADA STATE HEALTH DIVISION*	NSHD COMMUNITY HEALTH NURSING PROGRAM*	NORTHERN NEVADA HOPES	NORTHERN NEVADA OUTREACH TEAM
Type of Service	GLI, HC/PI	HC/PI, RWC	HC/PI, CTR	ILI, HC/PI CTR, RWC	HC/PI, CTR
Evidence Based Intervention	VOCES				
HIV Testing	No	No	Yes	Yes	Yes
Target Population	Latino	ALL	ALL	ALL	ALL
Target Behavioral Risk Group	Y/YA	HIV+		HIV+	MSM, Y/YA
Type of Agency	CBO	State	State	CBO	CBO
Region	North (Washoe, FaR)	Statewide	Statewide (FaR)	North (Washoe, FaR)	North (Washoe, FaR)
Contact Information	3905 Neil Road, Suite #2. Reno, NV 89502 (775) 826-1818	For information call: (775) 684-5928	For office locations, please call: (775) 684-4200	467 Ralston St. Reno, NV 89503 (775) 348-2893	PO Box 6716 Reno, NV 89513 www.nnot.org

	NEVADA URBAN INDIANS	PLANNED PARENTHOOD MAR MONTE*	PLANNED PARENTHOOD SOUTHERN NEVADA	RENO'S BIGGEST LITTLE SISTERS	RENO-SPARKS INDIAN COLONY
HIV Prevention Center					
Type of Service	HC/PI	GLI, HC/PI, CTR	HC/PI, CTR	HC/PI	HC/PI, CTR
Evidence Based Intervention	Street Smart				
HIV Testing	No	Yes	Yes	No	Yes
Target Population	Native American	ALL	ALL	ALL	Native American
Target Behavioral Risk Group		MSM, Y/YA	Y/YA	MSM	
Type of Agency	CBO	CBO	CBO	CBO	Tribal
Region	North (Washoe, FaR)	North (Washoe, FaR)	South (Clark)	North (Washoe)	North (Washoe)
Contact Information	1475 Terminal Way #B Reno, NV 89502 (775) 788-7600	455 W. Fifth St. Reno, NV 89503 (775) 321-8711	3220 W Charleston Blvd Las Vegas, NV 89102 (702) 878-7776	PO Box 650 Reno, NV 89504 sisters@renosbiggestlittlesisters.org	2001 E. 2nd Street Reno, NV 89502 (775) 329-9929
	232 E. Winnie Lane Carson City, NV 89706 (775) 883-4439	4385 Neil Road #105 Reno, NV 89502 (775) 829-2211			

HIV Prevention Center	RICHARD STEELE BOXING CENTER	SIN CITY SISTERS	SOUTHERN NEVADA HEALTH DISTRICT*	ST. THERESE	UMC WELLNESS
Type of Service	HC/PI	HC/PI	ILI,HC/PI,CTR RWC, PS	GLI, ILI, HC/PI	RWC
Evidence Based Intervention	CRCS				
HIV Testing	No	No	Yes	No	No
Target Population	African American, Latino/a	ALL	ALL	ALL	ALL
Target Behavioral Risk Group		HIV+	HIV+	HIV+	HIV+
Type of Agency	CBO	CBO	County	FBO	County
Region	South (Clark)	South (Clark)	South (Clark, FaR)	South (Clark)	South (Clark)
Contact Information	2475 W Cheyenne Ave # 110 N. Las Vegas, NV 89032 (702) 638-1308	(702) 205-7794 Sister Sioux (702) 591-6969 Sister Loosy for information	625 Shadow Lane Las Vegas, NV 89106 (775) 759-0702	100 E. Lake Meade Pkwy Henderson, NV 89015 (702) 564-4224	701 Shadow Ln Suite 200 Las Vegas, NV 89106 (702) 383-2691

HIV Prevention Center	UNLV STUDENT HEALTH CENTER	UNR STUDENT HEALTH CENTER	VICTORY MISSIONARY BAPTIST CHURCH	WASHOE COUNTY HEALTH DISTRICT*	WASHOE COUNTY JUVENILE DETENTION CENTER
Type of Service	HC/PI, CTR	HC/PI, CTR	HC/PI	ILI, HC/PI, CTR, PS	CTR
Evidence Based Intervention					
HIV Testing	Yes	Yes	No	Yes	Yes
Target Population	Y/YA	Y/YA	ALL	ALL	YA
Target Behavioral Risk Group	Y/YA	Y/YA		HIV+, Y/YA	Y/YA
Type of Agency	State	State	FBO	County	County
Region	South (Clark)	North (Washoe)	South (Clark)	North (Washoe, FaR)	County North (Washoe)
Contact Information	4505 S. Maryland Pkwy Las Vegas, NV 89154 (702) 895-0666	1664 N. Virginia Street Redfield Building M/S 196 Reno, NV 89557 (775) 784-6598	500 W. Monroe Ave Las Vegas, NV 89106 (702) 648-2286	1001 E. 9th St., Building B Reno, NV 89512 (775) 328-2470	650 Ferrari-McLeod Blvd. Reno, NV 89512 (775) 325-7800

RESOURCE INVENTORY ACRONYMS

Types of Service

CTR	Counseling, Testing, and Referral
GLI	Group Level Intervention
HC/PI	Health Communication and Public Information
ILI	Individual Level Intervention
PS	Partner Services
RWC	Ryan White Care (Part A or B)

Type of Intervention

CRCS	Comprehensive Risk Counseling Services
------	--

Target Behavioral Risk Group

HIV+	Human Immunodeficiency Virus Positive
IDU	Injection Drug Users
MSM	Men Who Have Sex With Men
Y/YA	Youth/Young Adult

Type of Agency

CBO	Community Based Organization
County	County Government
FBO	Faith Based Organization
Rural	Agency providing services primarily to rural Nevada
State	State Government
Tribal	Tribal Government

Service Definitions

CTR

Counseling, Testing, and Referral Services refer to services relating to HIV testing following CDC recommendations of providing comprehensive pre- and post-test counseling, including risk assessment and risk reduction strategies, administration of testing, and referral to ancillary services.

GLI

Group Level Interventions refer to providing information, education, support and skills building to prevent the acquisition or transmission of HIV to groups of individuals at highest risk.

HC/PI

Health Communication and Public Information refer to providing HIV prevention health information and education at community events, health fairs, and other venues. HC/PI can also refer to advertising and social marketing HIV prevention efforts in the local community.

ILI

Individual Level Interventions refer to short term health education and risk reduction counseling provided to one client at a time for one to three HIV prevention sessions usually lasting more than 20 minutes, such as case management. Does not include HIV prevention outreach or HIV counseling and testing.

RWC

Ryan White Care services provide medical, drug assistance, and other care services to those infected with HIV or AIDS.

Intervention/Service Definitions

CRCS

Comprehensive Risk Counseling and Services (formerly called Prevention Case Management): Intensive, ongoing and individualized health education and risk reduction counseling. A client centered activity for clients with multiple, complex problems and risk reduction needs. This intervention is more intensive than individual level interventions with multiple sessions specifically focusing on the reduction of risk for acquiring or transmitting HIV.

Street Smart

A multi-session, skills-building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use.

PS

Partner Services: Disclosure assistance to help HIV positive individuals disclose their HIV status in any of the following three situations: 1) on their own (self-disclosure), 2) in the presence of a partner and counselor (dual disclosure) or 3) referral for third party notification in which authorized Health District staff anonymously notifies partners of potential exposure to HIV.

Mpowerment

This community-level intervention for young men who have sex with men uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages.

Holistic Health Recovery

The Holistic Health Recovery Program (HHRP) is a 12-session, manual-guided, group-level program for HIV-positive and HIV negative injection drug users.

Healthy Relationships

Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.

VOICES/VOCES

Video Opportunities for Innovative Condom Education & Safer Sex: A group-level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics delivered in English (VOICES) and Spanish (VOCES).

PART THREE | GAP ANALYSIS

- Representatives from the Northern Nevada Planning Council and the Community Planning Group of Southern Nevada met to review the data from the needs assessment and resource inventory.
- Based on the reported HIV prevention needs and services provided, gaps were identified.
- Determined HIV prevention service gap information was used both in the determination of key target populations and in the recommendations of strategies and interventions sections of this plan.
- Common gaps were identified across all target populations at risk for HIV.
- Identified gaps will be addressed by the community planning groups in upcoming years and strategies will be discussed to fill those gaps.
- Additional information on HIV prevention service gaps can be found in Section Six: HIV Prevention Goals, Interventions, and Strategies.

SECTION FIVE

PRIORITIZED TARGET POPULATION

The priority populations for the Nevada State HIV Prevention Plan were determined through the following steps:

1. Review of the 2008 and 2009 HIV Epidemiological Profile to the Statewide Community Planning Committee.
2. Discussion of groups with the highest rates of HIV infection.
3. Discussion of groups with the emerging upward trends of HIV infection.
4. Review of the Community Services Assessment by the Statewide Community Planning Committee:
 - a. Review of relevant data from the 653 Key Informant Surveys collected statewide from July 2008 – March 2009.
 - b. Review of relevant data from 96 MSM Risk Behavior Surveys collected among MSM focus group participants collected statewide from March 2009 to May 2009.
 - c. Review of relevant data from the 22 focus groups, 194 participants, held statewide from March 2009 – November 2009.
 - d. Review of relevant data from the Community Resource Inventory Surveys collected statewide from September 2008 – March 2009.
5. Discussion of identified at-risk populations and needs, met and unmet, through the Community Services Assessment.

6. Determination of key priority populations based upon 2008 and 2009 HIV Epidemiological Profile and Community Services Assessment by the State wide Community Planning Committee.
7. Presentation of key data and priority population determination to the Community Planning Group of Southern Nevada (CPG SoN) and the Northern Nevada HIV/AIDS Planning Council (NNPC) in March 2010.
8. Vote of support and adoption of priority populations by CPG SoN and NNPC in March 2010.

Rank	Priority Population*
1.	MSM
2.	HIV+
3.	Youth/Young adults**
4.	IDU

* All interventions for priority populations MUST include BOTH:

1. an emphasis on minority populations disproportionately affected by HIV (specifically African-American and Latino/a)
2. a component regarding the influence of substance use on sexual risk taking behavior.

** Subpopulations for Youth and Young Adults to include MSM Youth and Heterosexual Youth.

Description and Justification of Priority Populations

MSM

In Nevada in 2008, 71 percent of the newly diagnosed HIV infections had a primary risk of MSM. Over the past five years (2005-2008), the number of newly diagnosed cases reporting MSM as primary risk factor has increased 33 percent.

Although Whites accounted for the greatest proportion of new cases among MSM, Nevada is experiencing significant increases among new MSM cases for both Blacks and Hispanics.

Additionally, over half (60 percent) of the persons identified living with HIV and AIDS in Nevada reported MSM as the primary risk of transmission. The high prevalence of HIV among gay and bisexual men means MSM are at elevated risk for being exposed to the infection during each sexual encounter.

Therefore, MSM was determined to be the top priority population for the Nevada State HIV Prevention plan due to the rates of HIV infection among this population.

Key focus areas within this population would include:

1. MSM who seek out sexual partners via the internet, including chats rooms and classified postings (ie: craigslist.org, gay.com, manhunt.net, etc)
2. Partners of MSM, including female sex partners of non-identifying MSM
3. MSM engaging in high-risk sexual activity under the influence of alcohol and/or drugs.

Special emphasis should be placed on minority populations, with a special emphasis on African-American and Latino/a groups, who are disproportionately affected by HIV.

HIV+

Due to increase in treatment options for individuals infected with HIV, people have been living longer, healthier lives with HIV and AIDS. There are approximately 7,940 people living with HIV/AIDS in Nevada in 2008, over half (52 percent) of the cases are AIDS cases.

The number of persons living with HIV (not AIDS) in Nevada increased over the past five years by 34 percent while the number of persons living with AIDS has increased by 20 percent during this time period. As there are more HIV infected individuals living with HIV/AIDS in Nevada, there is an increased likelihood for transmission of the virus to HIV negative individuals during sexual encounters and with injection drug contacts.

Prevention efforts targeting HIV positive individuals in order to reduce the spread of transmission has been prioritized as the second priority population in Nevada.

This prioritization points to the importance of HIV prevention among those currently infected in order to deter the spread of HIV infection among non-infected sexual or needle-sharing partners.

Special emphasis should be placed on minority populations, with a special emphasis on African-American and Latino/a groups, who are disproportionately affected by HIV.

Youth/Young Adults

Youth and Young Adults were determined to be the third priority population in Nevada due to emerging upward trends of newly diagnosed HIV infection among this population.

Over the past five years, there has been a 12 percent and nine percent increase in new HIV infections among the number of youth (13-24) and young adults (25-34), respectively. The rate of new HIV infections among youth in 2008 was 13.6 cases per 100,000 population and the rate among young adults was 29.9 cases per 100,000.

Minority youth and young adults are especially at a notable risk for HIV infection. Blacks accounted for over one-third of the new HIV infections among youth (34 percent) and young adults (32 percent) while Hispanics accounted for almost one-quarter for youth (23 percent) and young adults (23 percent); for both ethnic/minority groups there are increasing trends of new HIV infections in Nevada.

Youth and Young Adults are defined as those between the ages of 13 and 34. The two sub-populations among this priority group would be:

1. MSM Youth and Young Adults, ages 13 – 34
2. Heterosexual Youth and Young Adults, ages 13 – 34

Key focus areas within this population would include:

1. Youth/Young Adults who seek out sexual partners via the internet, including chats rooms and classified postings.
2. Youth/Young Adults engaging in high-risk sexual activity under the influence of alcohol and/or drugs.

Special emphasis should be placed on minority populations, with a special emphasis on African-American and Latino/a groups, who are disproportionately affected by HIV.

IDU

The fourth priority population is Injection Drug Users (IDUs). The current proportion of HIV infection through IDU exposure is eight percent statewide and MSM/IDU new infection are four percent statewide, accounting for 12% of total infections.

Over the past five years, there has been a 8% increase in the number of new HIV infections among IDU and 46% increase among MSM/IDU. This risk of HIV transmission is becoming a more pressing issue in Nevada as more people become infected through IDU, especially among males.

Although the majority of the IDU HIV cases are among white adults, there are upward trends among minorities and young adults. Special attention within this priority population should also be placed on sexual partners of IDUs, who are at increased risk of HIV infection.

Special emphasis should be placed on minority populations, with a special emphasis on African-American and Latino/a groups, who are disproportionately affected by HIV.

SECTION SIX

HIV PREVENTION GOALS, INTERVENTIONS, AND STRATEGIES

Based on the data collected, three over-arching goals have been established for prevention interventions and strategies in Nevada. These goals will place a special emphasis on the prioritized target populations.

The goals have been left in a general format to allow for community creativity and innovative design to meet specific prevention needs. At this point in time, specific numerical goals have not

been established since agency and community member reporting methods lack consistency.

It is anticipated that the community planning groups will work to develop uniform reporting mechanisms so that clear and accurate measurements can be collected across all agencies and community members doing HIV prevention work in Nevada.

GOAL ONE

Increase the number of people receiving HIV prevention awareness and education messages throughout Nevada, with a special emphasis on identified target populations.

GOAL TWO

Increase the number of people receiving HIV testing services throughout Nevada, with a special emphasis on identified target populations.

GOAL THREE

Increase the community capacity to provide referrals, supportive services, and linkages to care to those community

HIV PREVENTION INTERVENTIONS

The use of HIV prevention interventions is necessary throughout the state in order to accomplish these HIV prevention goals.

For the purposes of ensuring that these interventions are appropriate and effective for the target populations, it is imperative that community HIV prevention service providers are using best practices.

Therefore, interventions must fit into one of the following categories: Diffusion of Effective Behavioral Interventions (DEBIs), promising practices, or evidence-based practices.

All behavioral interventions must include minority populations (African American and Latino/a) and address substance use issues. Below is a list of suggested interventions; however, this list is not all-inclusive and is subject to change.

BEHAVIORAL INTERVENTIONS

TARGET POPULATION	INTERVENTION TYPE
Men who have Sex with Men (MSM)* *includes partners and internet	Many Men Many Voices D-Up: Defend Yourself Mpowerment Promise Project Explore
HIV Positive* *includes partners	Changes Project Holistic Health Recovery Willow Together Learning Choices Healthy Relationship Partnership for Health Clear

Injection Drug Users

Youth/Young Adults*

* includes MSM and Heterosexual

MIP: Modelo de Intervención Psicomédica
Safety Counts
Shield
Real Men Are Safe: REMAS

Sihle: Sisters Informing, Healing, Living,
and Empowering
Focus on Youth
Be Proud, Be Responsible
Street Smart
Draw the Line, Respect the Line

HIV PREVENTION STRATEGIES

Although HIV prevention interventions that have proven results for identified target populations are ideal, the following HIV prevention strategies can also be useful in providing a comprehensive approach to HIV prevention efforts in Nevada.

These HIV prevention strategies were recommended by members of the community who aided in this community planning process and are reinforced by the data collected in the Community Services Assessment.

These strategies and target areas will aid in achieving Nevada's HIV prevention goals set forth in this plan. The community is encouraged to use creativity, innovation, and collaboration in the implementation of these strategies.

It is anticipated that the Northern Nevada Planning Council and the Community Planning Group of Southern Nevada will use these strategies to work on a collaborative and coordinated approach to HIV prevention efforts in Nevada for the next five years.

STRATEGIES

1. Increase the availability and reach of media campaigns
2. Increase the availability of online interventions
3. Increase the number and availability of interventions that address substance use
4. Expand the availability of free and low cost HIV testing
5. Increase condom availability and appeal
6. Increase the number and availability of youth-specific interventions

INCREASE THE AVAILABILITY AND REACH OF MEDIA CAMPAIGNS

THE NEED

- Community member frustration over lack of media attention on HIV/AIDS
- Current media campaigns only target the GLBTQI community and reinforce the stigma that associates HIV as a “gay disease”
- Pharmaceutical companies heavily promote HIV as a manageable chronic disease
- Sexuality and condom use still portrayed as negative, dirty, and unhealthy.

THE CURRENT RESOURCES

EZ 2 Stop Campaign:

Print (Q Vegas, LV Weekly),
Online (twitter, facebook), Promo
Materials
South
MSM, Y/YA

Narrowcast Campaign:

Print
South
MSM, Y/YA

GYT Campaign:

Print, Online (facebook,
myspace), Television, Promotional
Statewide
Y/YA

Bang It Out Safely Campaign:

Promotional
South
Y/YA

WELLcumReno Campaign:

Print, Online (gay.com, manhunt.net),
Website, Promotional
North
MSM

TurnOnReno Campaign:

Print, Online (myspace), Promotional
North
Y/YA

Spread Negativity Campaign:

Print, Website, Promotional
North
Y/YA

InSpot:

Website, Promotional
Statewide
HIV+, Y/YA, MSM

Step Up, Get Tested Campaign:

Print, Promotional
North
Y/YA (African American)

THE GAPS

- No current media campaigns targeting injection drug users
- Campaigns targeting specific minority communities and HIV+ populations need to be expanded
- No current radio campaigns and limited television marketing
- No current campaigns that feature celebrities, athletes, and politicians getting tested for HIV
- No current campaigns that demonstrate that while HIV can be treated effectively, living with HIV is not easy and drugs have many side effects.

THE RECOMMENDED STRATEGIES

- Expand media campaigns to portray safe sex in a healthy, fun, sexy way
- Reinforce safer sex messaging on a variety of media outlets to reach diverse populations, including those with a focus on Latinos/as and African-Americans
- Encourage discussion of condoms in movies and television shows
- Develop campaigns that feature celebrities, athletes, and politicians getting tested for HIV
- Flash statistics of the number of people who are unaware of their HIV infection to reinforce testing messages
- Create advertisements that demonstrate that while HIV can be treated effectively, living with HIV is not easy and drugs have many side effects
- Include prevention messages in restrooms of bars/clubs, airports, and casinos
- Include information about HIV/AIDS prevention at gas stations, grocery stores, and bus stops
- Develop more HIV prevention materials in Spanish.

INCREASE THE AVAILABILITY OF ONLINE INTERVENTIONS

THE NEED

- Increase in the availability and use of internet sites and phone applications that people use for the purpose of seeking sexual partners (ie: gay.com, adam4adam, craigslist, grindr, etc.)
- Increase in the availability and use of social networking and dating sites that people use for the purpose of seeking sexual partners (ie: facebook, myspace, match.com, etc.)
- Advances in technology allow people easier access to meet sexual partners in a private and efficient manner

THE CURRENT RESOURCES

EZ 2 Stop Campaign:

Online (twitter, facebook, myspace)
South
MSM, Y/YA

WELLcumReno Campaign:

Online (gay.com, manhunt.net) Website
North
MSM

Spread Negativity Campaign:

Website
North
Y/YA

InSpot:

Website
Statewide
HIV+, Y/YA, MSM

Disease Investigation Profiles:

gay.com, adam4adam, manhunt,
facebook, myspace
South
MSM, Y/YA, HIV+

Peer Education Profiles:

gay.com, manhunt, adam4adam,
facebook, myspace
Statewide
MSM, Y/YA

THE GAPS

- Limited staffing for active peer education
- Limited staffing for disease investigation
- No coordinated statewide internet interventions/marketing campaigns
- No active online intervention on craigslist
- Lack of interventions reaching out to MSM population in non-MSM online venues
- Limited educational outreach on online sites, such as chat room educational sessions

THE RECOMMENDED STRATEGIES

Increased online HIV prevention interventions may be the most efficient way to reach sexually active MSM, particularly those who do not self-identify as gay or bisexual, as well as younger populations.

- Require users of dating or sexual networking websites to click on a pop-up that acknowledges the importance of using condoms
- Display local links for HIV testing and services on the first page of websites
- Have peer educators create profiles and respond to ads with information about where to obtain free condoms and/or free testing
- Have peer educators set up an educational profile on social networking sites and 'friend' others
- Create social networking profiles (myspace, facebook, twitter) that send information about HIV prevention
- Have public health professionals host live chats where individuals can ask questions about HIV and other STDs
- Display HIV risk reduction pop-ups that will catch the attention of target populations (ie: using attractive models and positive promotion of safer sex)
- Randomly display innovative and diverse condom advertisements
- Include a standard place for HIV status disclosure on all sites
- Development of a sex-positive branding strategy that promotes safer sex and harm reduction approaches

INCREASE THE NUMBER AND AVAILABILITY OF INTERVENTIONS THAT ADDRESS SUBSTANCE USE

THE NEED

- Substance use is a growing issue in all communities throughout Nevada
- Used syringes are being found on streets and in parks throughout Nevada
- Community members stated that they engaged in the “most risky” sexual behavior while under the influence of alcohol and/or drugs
- Syringe access (needle exchange) is illegal in the state of Nevada

THE CURRENT RESOURCES

Street Smart
North
Y/YA

SAPTA Testing Sites
South
IDU

FACT
South
Y/YA

Street Outreach
(bleach kits, disbursement and education)
North
IDU

THE GAPS

- No statewide needle exchange program
- Lack of substance use interventions in Spanish
- Lack of online substance use interventions
- Lack of coordination between substance abuse agencies and HIV prevention efforts

THE RECOMMENDED STRATEGIES

- Implement a statewide needle exchange program
- Develop campaigns that highlight substance use as a risk factor for HIV
- Develop more substance use educational materials in Spanish
- Promote online substance abuse prevention efforts Increase the availability of substance abuse treatment for diverse populations
- Decrease the stigma surrounding addiction

EXPAND THE AVAILABILITY OF FREE AND LOW COST HIV TESTING

THE NEED

- Community members are engaging in risky sexual and/or needle sharing behavior; yet, these people are not getting tested for HIV due to barriers in cost and availability
- Minority communities, although disproportionately at risk for HIV, report less availability of free or low cost HIV testing options in their communities
- The Centers for Disease Control and Prevention recommend routine screening of HIV in health care settings for all adults
- There is community stigma around HIV testing; HIV testing has not yet been “normalized”

THE CURRENT RESOURCES

Free and low cost HIV testing is available at on-site and limited off-site locations statewide targeting MSM, Y/YA, and IDU.

HOPES

Rapid and Oral Standard
Free on-site testing
Free limited off-site testing
North

Washoe County Health District

Rapid, Oral Standard, and Blood Standard
Low cost on-site testing
Free limited off-site testing
North

Planned Parenthood

Rapid and Blood Standard
Low cost on-site testing
Statewide

Northern Nevada Outreach Team

Oral Standard
Free limited off-site testing
North

Southern Nevada Health District

Rapid, Oral Standard, and Blood Standard
Low cost on-site testing
Free limited off-site testing South

THE GAPS

- No rapid testing in the field | North
- Limited diversity in HIV testing providers | South
- No online HIV test result options
- Limited education to providers about routine HIV testing
- Lack of testing incentives for high risk populations
- Limited free off-site testing outreach to minority and heterosexual communities

THE RECOMMENDED STRATEGIES

- Offer more rapid testing to increase the number of people who receive their test results
- Offer more oral testing options to increase the number of people who are willing to test
- Test where straight-identifying people hang out (e.g., “straight” bars, clubs, and concerts) to reach MSM who are not “out” and high-risk heterosexuals
- Encourage testing at fraternities, sororities, and the dorms
- Offer testing in more “mainstream” locations (farmers markets, grocery stores, schools)
- Encourage providers to make HIV testing a routine part of medical exams
- Increase street-based HIV testing to reach sex workers and their partners
- Encourage testing with one’s partner
- Give incentives for testing (discounted admission to shows, free drinks, vouchers for STD screening and/or birth control)
- Offer testing at special events and/or host new community events for targeted populations at risk (i.e., block parties, Cinco de Mayo, and community barbecues)
- Expanding testing and outreach in the jails and in collaboration with probation and parole services

INCREASE CONDOM AVAILABILITY AND APPEAL

THE NEED

- Community members stated lack of accessible, free condom distribution locations
- Community stigma surrounding the purchase and/or use of condoms result in less frequent use
- Few bars and clubs offer free condoms
- Free condoms that are available lack appeal The Current Resources: Free, yet limited, condom availability in the Reno and Las Vegas areas at MSM and Y/YA targeted sites.

THE GAPS

- Lack of funding and resources for widespread condom availability
- Limited locations for free condom distribution sites
- Limited hours of operations for many free condom distribution sites
- Lack of funding and resources for “appealing” condoms

THE RECOMMENDED STRATEGIES:

- Widely distribute condoms in both gay and non-gay establishments, including mainstream locations such as barber shops, bus stops, movie theaters, dorms, bars, and clubs
- Advertise and provide a wider variety of condoms (range of flavors, colors, sizes)
- Couple condom distribution with campaigns that promote condom use as sexy and desirable
- Advertise locations of free/reduced-cost condoms
- Have nightclub bouncers hand out condoms as people enter the establishment
- Install condom machines at bars, clubs, and gyms
- Distribute condoms at locations frequented by youth such as skate parks, schools, Boys & Girls Club
- Actively hand out condoms in places of high-risk activity

INCREASE THE NUMBER AND AVAILABILITY OF YOUTH-SPECIFIC INTERVENTIONS

THE NEED

- Community frustration with the quality and content of sexual health education that is delivered in schools
- Urgent need to develop sexual health programs that involve parents and include the roles of home and community

- Youth have become de-sensitized to HIV prevention messages
- Youth see HIV as a chronic manageable disease
- Youth are more concerned with pregnancy prevention than HIV/STD prevention

THE CURRENT RESOURCES

Street Smart

High Risk and Homeless
Youth 13 – 24
North

MPowerment

MSM
Youth
20 - 29
South

RU12

Youth Group
LGBTQ and allies
South

17 - 24 Youth Group

LGBTQ and allies South

School Based Sexual Health Education Programs

Middle and High School Statewide

Creating Lasting Family Connections

Parents and Children
North

Parent Talk

Parents of Teens
North

Planned Parenthood Multi-session Sexual Health Education

Middle and High School Students
North

Teen Talk/Male Investment Program

Middle and High School Students
North

THE GAPS

- Limited resources and programming that target youth and young adults
- Lack of coordination and collaboration with sexual health education programming in school districts
- Lack of parent/child intervention programs
- Lack of peer sexual health education programs for youth
- Limited support groups for HIV+ youth and youth adults

THE RECOMMENDED STRATEGIES

- Develop sexual health education programs for parents and increase parent involvement in sexual health interventions.
- Advocate for consistent and comprehensive sexual health education programs throughout all school districts in Nevada.
- Include a discussion of homosexuality in sexual health programs
- Address the stigma associated with discussion of sexuality, birth control and HIV/STD testing
- Create programs where HIV-positive youth share their experience with other youth
- Create a “tip sheet” on how to bring up condoms with a partner distributed at youth-focused events
- Provide opportunities for youth to role-play condom negotiation
- Create peer education and mentorship programs for young MSM, as well as heterosexual youth

CONCLUSION

The members of the Northern Nevada Planning Council and the Community Planning Group of Southern Nevada hope that Nevadans Working Together: Nevada Comprehensive State HIV Prevention Plan 2011 – 2016 will serve as a guiding document for HIV prevention efforts in the state of Nevada.

This document is intended as a resource and a guide to ensure a coordinated, collaborative, and seamless approach to addressing the HIV epidemic in our local communities. We look forward to working together with other concerned community members to reduce the burden of HIV in our community.

Nevadans Working Together is dedicated to all of those infected and affected by HIV/AIDS in our community. Until there is a cure, we are committed to remain steadfast in our HIV prevention efforts.